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ABSTRACT

The report summarizes 1983 activities of a multiagency network for severely emotionally disturbed students. Introductory sections review the chronology of significant events for the project, present data from a needs assessment, and describe development of the Individual Therapeutic and Educational Program (ITEP). Sample ITEP forms and procedures regarding student demographic information, educational goals and objectives, and therapeutic goals and objectives are included. Additional project activities described include a videotape data collection procedure, application for funding of a community-based class program, surveys of 27 mental health professionals regarding services and interagency communication, development of a case management system, establishment of a multiagency evaluation consortium, and a description of an adolescent day treatment program. Staff job descriptions and a summary of the project evaluation are also provided. (CL)

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Pasco/Pinellas Multiagency Network for Severely Emotionally Disturbed Students

Report to the State of Florida SED Advisory Board

January 25, 1984

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

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sed network MEMO

TO: SED State Advisory Board

FROM: Lee Sherry, Project Manager

RE: Report to the State of Florida SED Advisory Board

The Pasco/Pinellas Multiagency Network for Severely Emotionally Disturbed Students (SED Network) has moved forward with stated project goals and objectives. 1983 has been a productive year for the Pasco/Pinellas SED Network.

This Report illustrates the direction the project is taking. It represents an update of activities for 1983. For 1984 the SED Network anticipates continued advances in the development of multiple agency cooperation in program planning and implementation.

The projects highlighted in this report represent a few of the activities begun by the SED Network. It is my perception that the SED Network is rapidly becoming an integral part of the service planning and provision system in HRS District V.

LS/maz

REPORT TO THE STATE OF FLORIDA
SED ADVISORY BOARD

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Project Staff

Project Manager

Dr. Lee Sherry has extensive professional experience in the field of education for the emotionally disturbed. His involvement in the public education system includes: (1) classroom teacher, (2) consultant, (3) program supervisor, (4) program development and (5) teacher educator. He has been an assistant professor at the University of Florida and the University of North Carolina at Charlotte. Dr. Sherry's numerous educational publications, professional reports, presentations and funded grants compliment his professional background.

Program Coordinator

Mr. Michael Tomalesky's professional background is in the area of clinical psychology. Mr. Tomalesky has worked as a school psychologist in public education and has served as Director of Children's Services in a mental health facility. In addition, he has participated in private family counseling practices. Mr. Tomalesky was instrumental in the writing of the SED Network Pilot Project.

Training and Resource Liaison (1)

Ms. Maureen Gale has been a teacher of emotionally handicapped children in the Alachua County Schools. Also, in HRS District IIIa, she was a teacher in the HRS school based ALPHA Prevention Project. In addition to her experiences in the education of exceptional students, she has held local, state, and national leadership positions in the Council for Exceptional Children (CEC). Presently, she is secretary of the Florida Federation of CEC.

Training and Resource Liaison (A)

Ms. Carol Violette has had a wide range of experiences in the education of severely emotionally disturbed children and youth. Her professional background includes classroom experiences with SED students in Virginia and Florida. She has taught in resource room satellite programs, self-contained and SED Center programs. She has been active in the Council for Children with Behavior Disorders (CCBD) and is presently Past-President of the Pinellas County CCBD.

SED Network Advisory Committee (1983)

The SED Network Advisory Committee represents the multi-district/multiagency effort to pool resources and personnel to provide an integrated continuum of services at the local level for SED children/youth. The Committee meets monthly to discuss SED Network staff progress in attaining stated goals and objectives of the Pilot Project. As an advisory panel, the Committee has become an integral part of the community's policy making and planning process. Listed below are all members of the SED Network Advisory Committee:

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PASCO/PINELLAS SED NETWORK

CHRONOLOGY OF

SIGNIFICANT EVENTS, 1983

January 14, 1983 -- SED Network Advisory Committee Meeting.

February 1, 1983 - The Pinellas County Schools and the Pinellas Young Peoples Residential Treatment Homes jointly established the intensive Adolescent Day Treatment Program.

February 18, 1983 - SED Network Advisory Committee Meeting.

February 22, 1983 - Pinellas County Schools Interview Committee met to screen Project Manager and Project Coordinator applications.

February 25, 1983 - SED Network Advisory Committee Meeting.

March 15, 1983 - SED Network Advisory Committee Meeting.

March 15, 1983 - Shawn Roach, Assistant Director, Funding and Planning, Juvenile Welfare Board, selected as SED Network Advisory Committee Chairperson, Pat Gehant, Director of Planning, District Mental Health Board V, selected as co-chairperson.

March 23, 1983 - Formal Pinellas County School Board approval of Dr. Lee Sherry as SED Network, Project Manager and Michael Tomalesky, Program Coordinator.

April 4, 1983 - Michael Tomalesky, Program Coordinator assumes position as first SED Network staff member.

April 15-16, 1983 - Members of Advisory Committee visit Bertha Abess Center, Miami to explore ITEP procedures.

April 19, 1983 - SED Network Advisory Committee Meeting.

May 11, 1983 - Dr. Lee Sherry, Project Manager, assumes position on SED Network Staff.

May 11, 1983 l- SED State Advisory Board Meeting.

May 17, 1983 - SED Network Advisory Committee Meeting.

June 15, 1983 - SED Network Staff Development Needs Assessment Survey completed.

June 15, 1983 - First T/IEP development meeting held.

June 21, 1983 - Advisory Committee approves the concept of the development of an Evaluation Consortium to monitor project goals, objecjtives and evaluation activities.

June 21, 1983 - SED Network Advisory Committee Meeting.

June 21, 1983 - Juvenile Wellfare Board completes the Mental Health Residential Needs Assessment Survey for SED students. The SED Network is named as facilitator for improvement of service options.

July 1, 1983 - Maureen Gale, Resource and Training Liaison joins the SED Network Staff.

July 1, 1983 - HRS District V, CYF, receives new funding for an adolescent day treatment program.

July 14, 1983 - Project manager presents SED Network goals and objectives to the Board of the Juvenile Welfare Board.

July 19, 1983 - SED Network Advisory Committee Meeting.

July 21, 1983 - Pinellas County Schools increases the number of EH and SED classes for 1983-84 by 13 units.

July 21, 1983 - SED Network staff (Michael Tomalesky) will have full representation on District V Case Review Committee.

July 21, 1983 - SED Network Advisory Committee approved including Juvenile Justice System representation on the Advisory Committee.

July 25, 26, 1983 - Site visitation to Lakeview Center, Pensacola, by SED Advisory Committee members.

July 27, 1983 - T/IEP Multiagency Development Committee meeting.

July 27, 1983 - Planning for Video tape validation of therapeutic effects begins.

August 1, 1983 - Carol Violette Resource and Training Liaison joins SED Network staff; all staff positions are filled.

August 11, 1983 - T/IEP Multiagency Development Committee Meeting.

August 11, 1983 - Multiagency planning begins on the development of the Community Based Program.

August 16, 1983 - SED Network Advisory Committee Meeting.

August 16, 1983 - Evaluation Consortium Plan forwarded and approved by Advisory Committee. All Consortium personnel selected.

August 16, 1983 - T/IEP becomes ITEP as multiagency development team begins to finalize plans.

August 18, 1983 - Project Manager presents SED Network concept to FCCMH Children's Conference, Tampa.

August 26, 1983 - Resource and Training Liaisons begin data collection procedures with education and mental health direct service providers.

August 26, 1983 - The District School Board of Pasco County and the Human Development Center of Pasco formally initiate the Comprehensive Adolescent Day Treatment Program in New Port Richey.

August 26, 1983 - Pinellas Young People's Residental Treatment Homes moves its Intensive Adolescent Day Treatment Program to Safety Harbor Exceptional Student Center.

August 28, 1983 - SED Network staff present the pilot projects goals and objectives to teachers and school based support personnel at the FDLRS Gulfcoast Educational Conference.

August 30, 1983 - ITEP Multiagency Development Committee Meeting.

August 31, 1983 - Pinellas County Schools adopts ACT Procedures consistent with DHRS guidelines.

September 2, 1983 - SED Network staff begin planning teacher support group procedures

September 7, 1983 - Case Management Systems Development Committee is established.

September 12, 1983 - SED Network staff invited to join FDLRS Advisory Committee.

September 12, 1983 - ITEP approved by Development Committee; recommendation forwarded to SED Advisory Committee.

September 13, 1983 - SED Network presentation to the Planning Committee of the District Mental Health Board V, Inc.

September 16, 1983 - SED Network and SED/NET Project Managers meet to discuss future pilot project interactions.

September 19, 1983 - SED Network Evaluation Consortium organization meeting.

September 20, 1983 - Advisory Committee approves ITEP documentation plan.

September 28, 1983 - Pinellas County School Board formally approves Evaluation Systems Design, Inc., as the SED Network evaluation consultant.

September 28, 1983 - Project Manager presents an orientation of the SED Network goals, objectives and activities to the Board of the District Mental Health Board V, Inc.

October 4-5, 1983 - SED State Advisory Board Meeting.

October 14, 1983 - SED Network sponsors three presentations at the Florida Federation Council for Exceptional Children Convention in Miami Beach.

October 14, 1983 - The Coalition for the Education for Exceptional Children includes an item supporting DHRS and DOE budget items for continuation of current services for SED students and the addition of new programs in their Legislative Platform.

October 17, 1983 - SED Network staff discuss Community-Based Classroom with Mental Health Services of South Pinellas (MHSSP) staff. MHSSP agrees to provide mental health support and will assist in seeking local funding from JWB.

October 17, 1983 - Evaluation Consortium Meeting.

October 17, 1983 - Evaluation Consortium considers uniform psychological data collection procedures for SED students across all agencies.

October 18, 1983 - Multiagency planning begins to develop a regional conference for EH and SED professionals.

October 20, 1983 - SED Network Advisory Committee Meeting.

October 20, 1983 - SED Network staff invited to join Youth Services Advisory Committee (YSAC).

October 21, 1983 - SED Network staff and Advisory Committee members visit Eckerd's Camp E-How-Kee in Brooksville.

October 21, 1983 - SED Network staff invited to participate in the HRS/School Community Control Committee.

October 24, 1983 - Alternative Human Services organizes the Information & Referral Manual for SED professionals.

October 28, 1983 - Staff development activities presented by SED Network staff to all SED teaching personnel in the Pinellas County Schools.

October 28, 1983 - SED Network and District Mental Health Board staff members meet with YSAC to plan strategies for delivery of elementary level day treatment programs.

November 2, 1983 - Lee Sherry and Michael Tomalesky present the SED Multiagency concept at the Florida Association of School Psychologists Annual meeting.

November 3-4, 1983 - Resource and Training Liaison invited to FSU to participate in building competencies for SED teachers.

November 4, 1983 - SED Network and DMHB staffs initiate the planning process for LBR development of Case Management and Elementary Day Treatment services for SED students.

November 8-10, 1983 - Department of Education, Bureau of Education for Exceptional Students audits SED Network budget, goals, objectives and management.

November 11, 1983 - Case Management Systems Development Committee meeting at JWB (Hospital personnel attended for first time).

November 11, 1983 - SED Network staff begin participation in referral review for Community-Based Classroom Program.

November 14, 1983 - Evaluation Consortium Meeting.

November 14, 1983 - Community-Based Classroom proposal submitted to Juvenile Welfare Board for funding the mental health component.

November 15, 1983 - Evaluation of the ITEP development process initiated.

November 15, 1983 - New South Pinellas Adolescent Day Treatment program (CYF Funded) planning meeting with Pinellas County Schools, Mental Health Services of South Pinellas and SED Network staff.

November 15, 1983 - SED Network Advisory Committee Meeting.

November 18, 1983 - SED Network staff advocate for Children's Mental Health Services. Pinellas County schools places this issue on its 1984 Legislative Program.

November 23, 1983 - ACT and Medication Administration Policy development meeting with Pinellas Young Peoples Residential Treatment Homes Inc. staff.

November 29, 1983 - South Pinellas Adolescent Day Treatment Program planning meeting.

December 2, 1983 - The District V Case Review Committee agrees to tackle the task of developing the SED Definition.

December 5, 1983 - Meeting with SED Center personnel to establish therapeutic groups in the SED Centers.

December 8-9, 1983 - Training and Resource Liaisons attend Developmental Play workshops presented by Dr. Vi Brody.

December 9, 1983 - Pinellas County Schools initiates the SED Task Force. This group will make recommendations to improve the quality of SED programs in the schools.

December 9, 1983 - Pinellas Young People's Residential Treatment Homes Inc. Board Meeting (Dr. Sherry's first as a Board Member).

December 12, 1983 - Resource and Training Liaison complete interview and summaries of all mental Health service providers in HRS District V.

December 12, 1983 - Evaluation Consortium Meeting.

December 12, 1983 - Evaluation Consortium begins consideration of how it may participate in the state-wide SED Multiagency Network evaluation.

December 13, 1983 - SED Network Advisory Committee Meeting.

December 13, 1983 - YSAC presents recommendations for elementary level day treatment program to SED Advisory Committee.

December 13, 1983 - Evaluation of SED Network Advisory Committee functioning initiated.

December 13, 1983 - Pat Gehant elected Chairperson, SED Network Advisory Committee for 1984. Mike Meredith, Behavioral Specialist, Pasco County Schools elected co-chairperson.

December 13, 1983 - SED Network luncheon for Advisory Committee members and cooperating agency Directors/Executive Directors.

December 14, 1983 - ITEP Phase II Development Meeting. Initial multiagency work begins on developing comprehensive hierarchies of academic and therapeutic goals and objectives.

December 15, 1983 - The District Mental Health Board submitted the Legislative Budget Request (LBR) to Tallahassee. Included in the LBR is a request for funds for case management services for children and elementary level day treatment services.

December 16, 1983 - Juvenile Welfare Board staff recommend JWB funding for the mental health component of the Community-Based Classroom Program.

STAFF DEVELOPMENT NEEDS ASSESSMENT

During the spring of 1983 a Staff Development Needs Assessment Survey was developed and administered to all teachers of the severely emotionally disturbed (SED) and support personnel in the Pinellas and Pasco County Schools. Support personnel included behavioral specialists, school psychologists, and social workers.

ASSESSMENT DEVELOPMENT COMMITTEE

The needs assessment survey was developed by a multiagency team with members representing education and mental health direct service providers. Participants in the development of the survey are listed below:

Karen Amundrud
Behavioral Specialist
Richard L. Sanders School
Pinellas County Schools

Michael Bessette
Behavioral Specialist
Safety Harbor Exceptional Student Center
Pinellas County Schools

Michael Fitzgerald
Social Worker
Intensive Adolescent Day Treatment Program
Pinellas Young Peoples Residental Treatment Homes

Dennis Harrison
Behavioral Specialist
Richard L. Sanders School
Pinellas County Schools

Betty Kjera, Ph.D.
Clinical Psychologist
Human Development Center of Pasco

Michael Meridith
Behavioral Specialist
Moon Lake Elem. School
Pasco County District School Board

David Riordan
Teacher (SED)
Adolescent Day Treatment Program
Mental Health Services of Upper Pinellas/Pinellas County Schools

Michael Tomalesky
Program Coordinator
SED Network

Carol Violette
Teacher (SED)
Safety Harbor Exceptional Student Center
Pinellas County Schools

The team assembled a comprehensive questionnaire assessing in-service training needs in four areas: (1) general awareness, (2) curriculum options, (3) behavioral and affective techniques, and (4) opinions. The questionnaire is attached showing the frequency of responses for each question. The Likert Scale questions are displayed in percentages. The "yes/no" responses are displayed in actual frequencies (See Appendix A).

ASSESSMENT RESULTS

The training needs assessment survey was administered to 36 professionals and produced results that will be addressed by future training activities in HRS District V. Training will be provided by SED Network staff, Florida Diagnostic and Learning Resources System (FDLRS) personnel, and consultants contracted by cooperating agencies in the SED Network.

Results for each of the four areas assessed are discussed below. In the area of General Awareness, teachers and support personnel ranked five training needs of high or highest priority. These are training needs in:

General Awareness Training Needs
(High Priority)

62.8% Psychological therapies; such as group, individual and process therapies.

57.1% How do other handicaps such as learning disabilities and/or neurological problems affect teaching SED students.

55.7% What effects do psychoactive medication have on SED student behavior?

46.8% How and when should I consider hospitalizing a student?

41.6% What do local hospitals have to offer the SED student?

Items receiving low rankings for training needs are listed below:

General Awareness Training Needs
(Low Priority)

14.7% The Diagnostic and Statistical Manual (DSM-III), its use and contents.

20.6% How to understand DSM-III technical terms (what do they mean)?

23.5% How to apply DSM-III Diagnoses to practical classroom/clinic activities.

25% What is the Baker Act, how does it work for hospitalization.

27.8% What is a seizure? What do I do?

In the area of Curriculum Skills, direct service providers ranked all items as high or highest priority for training needs. The percent of respondents ranking high priorities are listed below:

Curriculum Skills Training Needs
(High Priority)

72.2% Develop an affective skills training component in my class.

55.6% Develop specific academic materials for use with SED students.

52.8% Incorporating vocational materials in SED classes.

52.8% Incorporating self-help skills such as home care, family relations, and sex education in SED classes.

Behavioral and Affective techniques all received high priority rankings from respondents. All are considered as training needs. Listed below are the five highest ranked items:

Behavioral/Affective Training Needs
(High Priority)

80.6% Crisis intervention techniques.

74.3% Modeling and role playing for affective development of SED students.

74.2% Improved listening and communication skills (beyond the basics).

72.7% Relaxation exercises with SED children and youth.

68.6% Developmental play and/or variations of this process.

In the section titled Opinion, direct service providers were asked to respond by marking "yes/no" answers. The greatest frequency of "yes" responses are listed below:

Greatest Frequency of
"Yes" Opinion Responses

n = 34 Do you think therapists specializing in art, music or movement therapy should be part of the SED program?

n = 33 Teachers/staff working with SED children should learn relaxation skills for their own benefit.

n = 31 Do you think inservice training is useful? Should inservice be scheduled during normal working hours?

n = 30 SED professionals need support groups in which to develop their personal/professional goals.

n = 29 Do you think volunteers can be useful in the SED classroom?

Of interest was the response that reflected respondent's opinions regarding their formal professional preparation. Overwhelmingly, teachers and support personnel responded that they felt that their college/university training did not prepare them adequately. Only two respondents felt that their formal training prepared them to be effective SED teachers (see item #10, section III. Opinions, Appendix A).

When asked the type of inservice program preferred, respondents reported that they liked lecture workshops with large audiences and some experiential activities. In general, this type of inservice can be planned and implemented in a cost effective manner by SED Network participating agencies.

SUMMARY

In general, teachers and support personnel working with SED children and youth in HRS District V viewed their training needs as broad. In the areas of general awareness, curriculum and behavioral/affective techniques one major trend was revealed in survey responses. Specifically, teacher and support personnel identified a strong need for inservice training in the area of psychological therapies/affective education skills.

Traditionally, SED teachers have not been requested to implement therapeutic strategies in their classrooms. Primary emphasis has been placed on behavior management and academic remediation. The results of the present survey suggest that an additional area of training is a must--psychological/therapeutic intervention.

STAFF DEVELOPMENT
NEEDS ASSESSMENT

This questionnaire addresses Inservice Training Needs as well as other topics related to training. Please take a few minutes to complete each question. Your input will be used to develop inservice training sessions for the 1983-84 school year. Please feel free to make comments at the end of the questionnaire. Express your opinions.

Thank you,
Needs Assessment Committee

I. GENERAL INFORMATION

My sex is: ___male ___female

My age group is: ___20-25 ___26-30 ___31-35 ___36-40 ___41-+

I have, ___0-2, ___3-5, ___6-10, ___11+, years of experience working with Severely Emotionally Disturbed students.

I presently work with this age group: ___0-5, ___6-10, ___11-15, ___16-21.

I am housed in: ___Regular School ___SED Center
___Day Treatment ___Mental Health Facility

II. INSERVICE TRAINING

Check one ___ to indicate priority of topic:

	5 Highest Priority	4 High Priority	3 Priority	2 Low Priority	1 No Priority
A. GENERAL AWARENESS					
I would like to learn more about:					
1. The Diagnostic and Statistical Manual (DSM III), its use and contents;	8.8	5.9	29.4	26.5	29.4
2. How to understand DSM III technical terms; (what do they mean?);	5.9	14.7	23.5	32.4	23.5
3. How to apply DSM III Diagnoses to practical classroom clinic activities;	5.9	17.6	35.3	20.6	20.6

	5 Highest Priority	4 High Priority	3 Priority	2 Low Priority	1 No Priority
4. How to recognize a student's serious health/medical problem;	8.3	25.0	36.1	27.8	2.8
5. What effects do psycho-medical drugs have on EH/SED student behavior?	22.2	33.3	16.7	22.2	5.6
6. What is a seizure? "What do I do?"	2.8	25.0	25.0	27.8	19.4
7. Street Drugs and SED student behavior. What kinds of drugs, what effects?	5.6	33.3	36.1	13.9	11.1
8. How do other handicaps such as learning disabilities and/or neurological problems affect teaching and/or working with EH/SED students?	20.0	37.1	31.1	5.7	5.7
9. Psychological Therapies: such as, group, individual, process types. What are they? Should/can I do them?	45.7	17.1	25.7	8.6	2.9
10. Specialized Therapies:					
a. Music therapy	21.2	21.2	39.4	9.1	9.1
b. Art therapy	27.3	27.3	33.3	6.1	6.1
c. Movement therapy	27.3	30.3	18.2	18.2	6.1
d. Adaptive Physical Education;	33.3	18.2	21.2	21.2	6.1
11. Who are Mental Health Professionals, how are they trained, what do they do?	5.6	16.7	25.0	27.8	25.0
12. Health & Rehabilitative Services (HRS); What do they offer?	8.6	22.9	28.6	17.1	22.9
13. Child Abuse; its impact on EH/SED students;	13.9	25.0	41.7	11.1	8.3
14. Child abuse, how to report it, "what legal ramifications do I face?	14.3	17.1	31.4	28.6	8.6

	5 Highest Priority	4 High Priority	3 Priority	2 Low Priority	1 No Priority
15. What is the Baker Act, how does it work for hospitalization?	8.3	16.7	33.3	30.6	11.1
16. How and when should I consider hospitalizing a student?	19.4	27.8	13.9	27.8	11.1
17. What do the local hospitals have to offer the EH/SED student?	19.4	22.2	33.3	30.6	11.1
18. How can I use a classroom volunteer more effectively?	11.1	22.2	25.0	27.8	13.9
B. CURRICULUM AREAS					
I would like to learn more about:					
1. Incorporating vocational material in classes I teach;	36.1	16.7	16.7	16.7	13.9
2. Specific academic materials for use with EH/SED student;	27.8	27.8	25.0	11.1	8.3
3. Incorporating self-help skills such as home care, family relations, sex education in classes I teach;	22.2	30.6	27.8	8.3	11.1
4. Developing an affective skills training component in my class:	47.2	25.0	13.9	8.3	5.9
C. BEHAVIORAL AND AFFECTIVE TECHNIQUES					
I would like to learn to utilize:					
1. Behavior Modification techniques that go beyond token economies; such as, shaping, fading, etc.;	40.0	17.1	14.3	25.7	2.9
2. Video production and prerecorded tapes in teaching and learning affective skills;	25.0	25.0	30.6	16.7	2.8

	5 Highest Priority	4 High Priority	3 Priority	2 Low Priority	1 No Priority
3. Developmental Play and/ or variations of this process;	42.9	25.7	8.6	14.3	8.6
4. Modeling and Role playing for affective development of EH/SED students;	45.7	28.6	14.3	11.4	0
5. Crisis Intervention Techniques: Verbal (talk-down) Physical (restraint)	55.6	25.0	13.9	2.8	2.8
6. Relaxation exercises with EH/SED children;	48.5	24.2	18.2	6.1	3.0
7. Improved listening and communication skills; techniques beyond the basics;	37.1	37.1	14.3	8.6	2.9
8. Team teaching approaches in EH/SED programs;	30.6	36.1	16.7	13.9	2.8
9. Peer tutors and/or counselors in the classroom;	19.4	27.8	19.4	22.2	11.1
10. Involving community resources in the EH/SED classroom;	0.0	33.3	27.8	25.0	13.9
11. More effective parent conference techniques;	22.2	22.2	44.4	8.3	2.8

III. OPINIONS

Please respond to each question by checking the appropriate ___:

1. Teachers/staff working with EH/SED children should learn relaxation skills for their own benefit; 33 YES 3 NO

2. Would you participate in group relaxation training: 33 YES 3 NO

3. EH/SED professionals need support groups in which to develop their personal/professional goals; 30 YES 5 NO

4. Would you participate in a support group: 28 YES 4 NO

5. Do you think most EH/SED professionals are good listeners? 12 YES 3 NO

6. Are you a good listener? 26 YES 4 NO

7. Do you believe Team Teaching is an effective teaching method for EH/SED students? 23 YES 7 NO

8. Would you Team Teach? 26 YES 5 NO

9. Do you think therapists specializing in Art, Music, or Movement Therapy should be part of the EH/SED program? 34 YES 0 NO

10. Do you believe the University system (such as USF) provides sufficient training to prepare an EH/SED professional? 2 YES 25NO

11. Do you think volunteers can be useful in the EH/SED classroom? 29 YES 4 NO

12. Would you like to have a volunteer in your classroom? 25 YES 7 NO

13. Do you feel inservice training is useful? 31 YES 3 NO

14. Would you participate in a workshop after working hours? 28 YES 5 NO

15. Should inservice workshops be scheduled during normal working hours? 31 YES 4 NO

16. If YES in #15, should the trainer require mandatory attendance? 25 YES 8 NO

Please rank your preference
1 Highest/5 Lowest

17. Do you prefer:

18.	Lecture only workshops	1
19.	Experiential only workshops	4
20.	Some lecture, some experiential material	3
21.	Large audience	2
22.	Small groups	4

IV. COMMENTS:

Please make any additional comments about inservice training. Express your opinions; the types of workshops to be offered will be based on your input.

(Use back of page if necessary.)

INDIVIDUAL THERAPEUTIC AND EDUCATIONAL PROGRAM

The development of the Individual Therapeutic and Educational Program (ITEP) has been divided into three major phases. Phase I is the development of a documentation system. Phase II is the creation of (1) a Handbook of Educational and Behavioral Goals and Objectives, and (2) a Checklist of skills for both Educational and Behavioral activities. Phase III will be the development of Observation Instruments to assess the acquisition of Educational and Behavioral skills.

PHASE I

The ITEP Documentation System has been developed by a multiagency task force of professionals from both clinical and educational backgrounds. The task force, in a series of meetings, examined issues of confidentiality, client's rights and record keeping procedures. A working documentation system of forms was proposed. Review of the forms occurred in regularly scheduled meetings. The completed system presented here is the state-of-the-art in individual education and treatment programming for severely emotionally disturbed children and youth in Pinellas and Pasco Counties. The attached timeline indicates the plan to pilot the use of the ITEP Documentation System in four (4) Adolescent Day Treatment Programs in Pinellas and Pasco Counties as well as an experimental community-based classroom in South Pinellas County. The system will be reviewed and fine tuned based on feedback from education and mental health staffs piloting the system.

PHASE II

Two subcommittees of the Phase II task force have been organized. One subcommittee is comprised of teachers of the emotionally handicapped, severely emotionally disturbed, and learning disabled to review and develop the Educational Goals and Objectives section of the Handbook and Checklist. The checklist will be based on a sequential hierarchy of skill acquisition and will serve as a table of contents to the Educational Handbook section.

The other subcommittee, comprised of mental health and educational professionals, will develop the Behavioral Goals and Objectives Handbook and Checklist. Paralleling the Educational Handbook, the Behavioral Goals will also use a sequential hierarchy of acquired behavioral skills. The checklist will serve as a measure of acquired behavioral and affective skills. The child who has not mastered certain skills will be evaluated by use of the checklist. Subsequent skills to be taught will be identified based on the last obtained skill mastered on the Behavioral Checklist. Reference to the Behavioral Goals and Objectives Handbook, will afford the professional suggestions on how to help the child learn behavioral skills based on normal developmental sequences. Included in this summary is a list of the professionals involved in the Phase II task force.

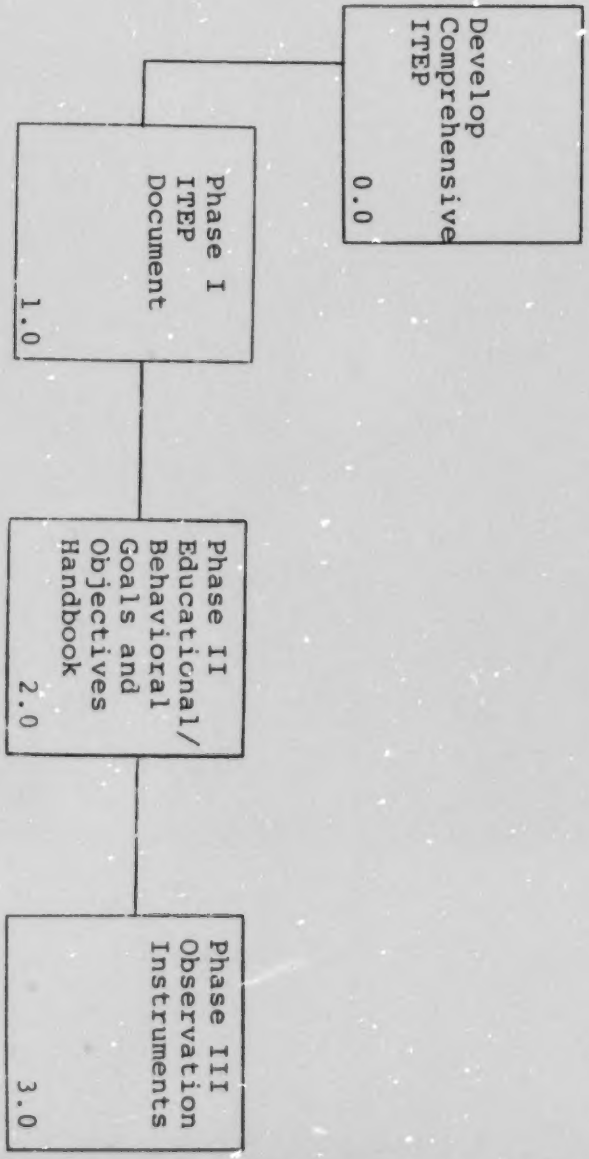
Phase III

Phase I provides a storage system of documents and written treatment plans for each child in the treatment program. Phase II represents the goals and objectives to be mastered by each child. The goals and objectives written in the plan will be drawn from the combined Phase II handbooks. The Phase III Task Force will develop Observation Instruments to be used in the treatment programs by the professional staff. The observation instruments will give education and mental health professionals the means of determining each child's mastery of both Educational and Behavioral skills. The anticipated beginning of the Observation Instrument development will be late 1984.

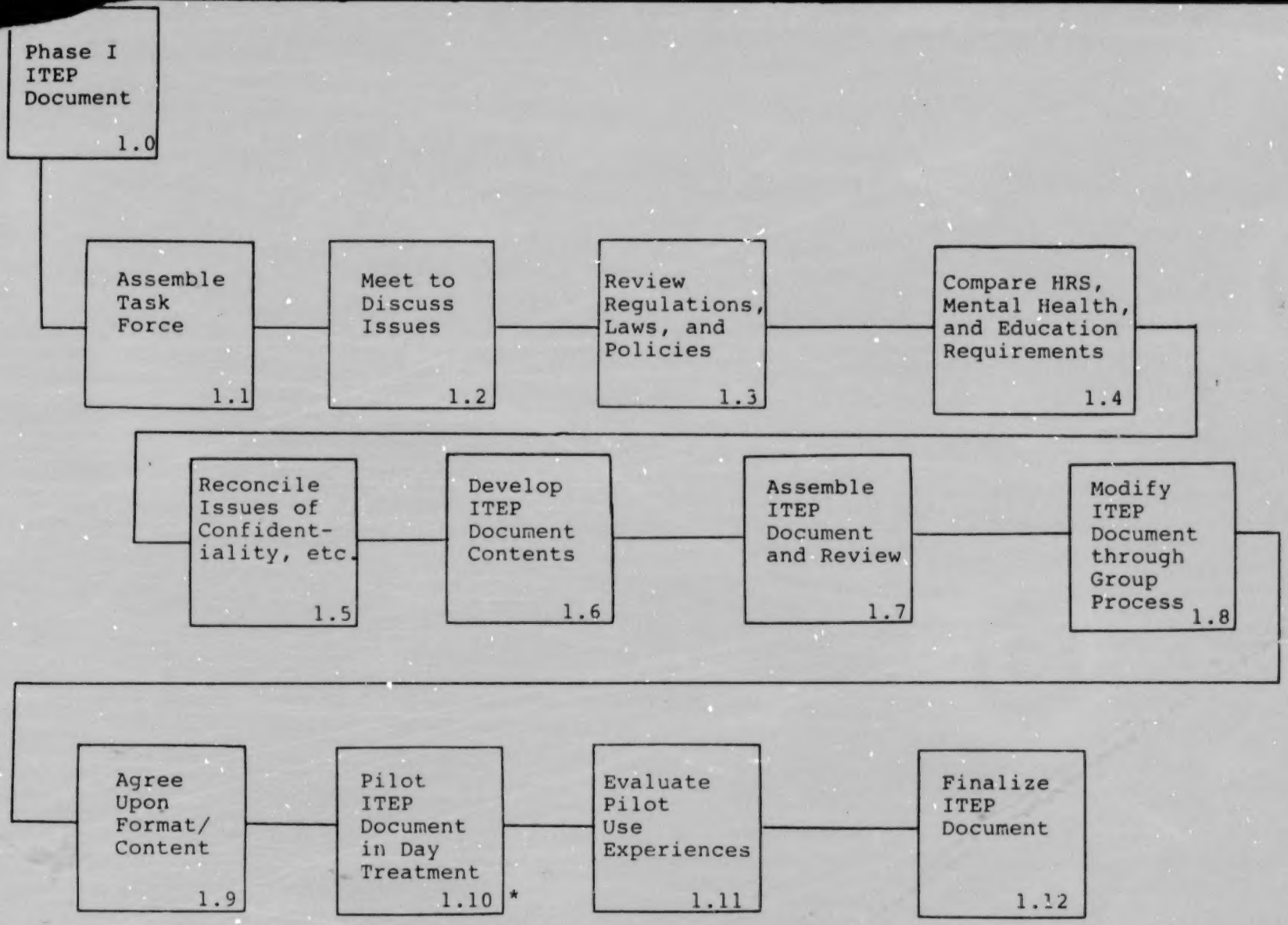
Individual Therapeutic and Educational Program

Development Sequence

Phases I, II, and III



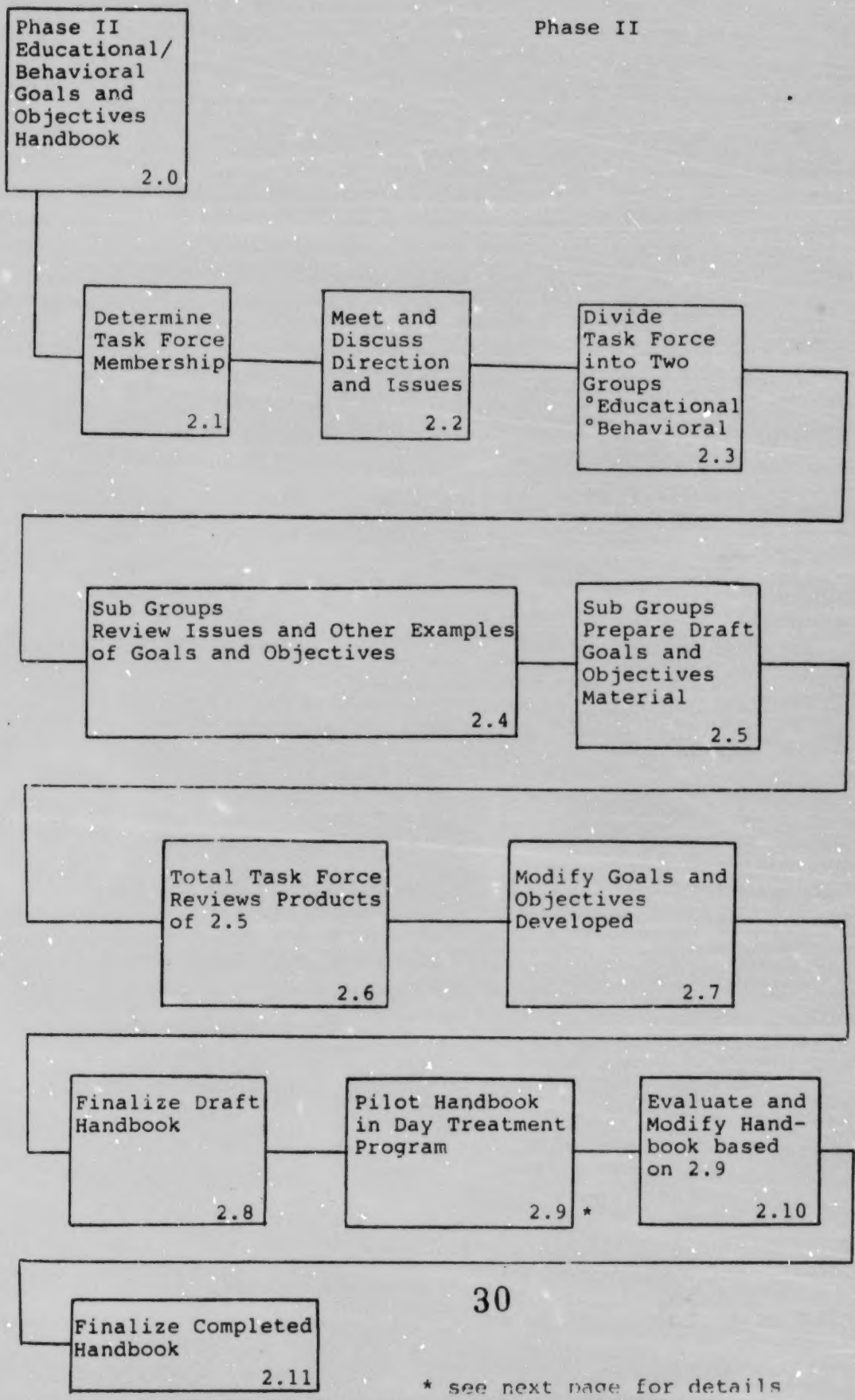
Phase I


Phase I ITEP Document 1.0
Assemble Task Force 1.1
Meet to Discuss Issues 1.2
Review Regulations, Laws, and Policies 1.3
Compare HRS, Mental Health, and Education Requirements 1.4
Reconcile Issues of Confident-iality, etc. 1.5
Develop ITEP Document Contents 1.6
Assemble ITEP Document and Review 1.7
Modify ITEP Document through Group Process 1.8
Agree Upon Format/ Content 1.9
Pilot ITEP Document in Day Treatment 1.10 *
Evaluate Pilot Use Experiences 1.11
Finalize ITEP Document 1.12

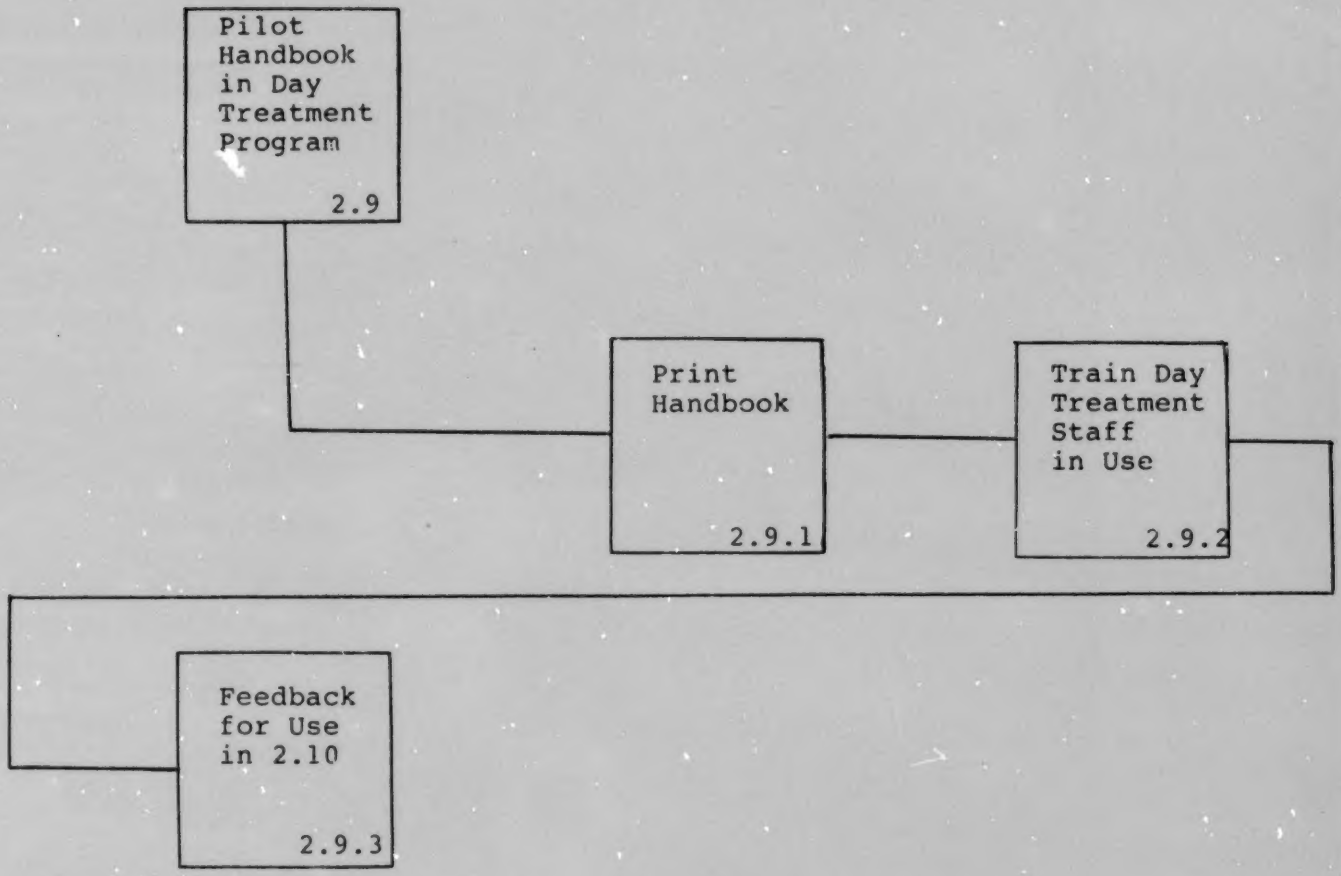
* see next page for details

Additional Details Phase I

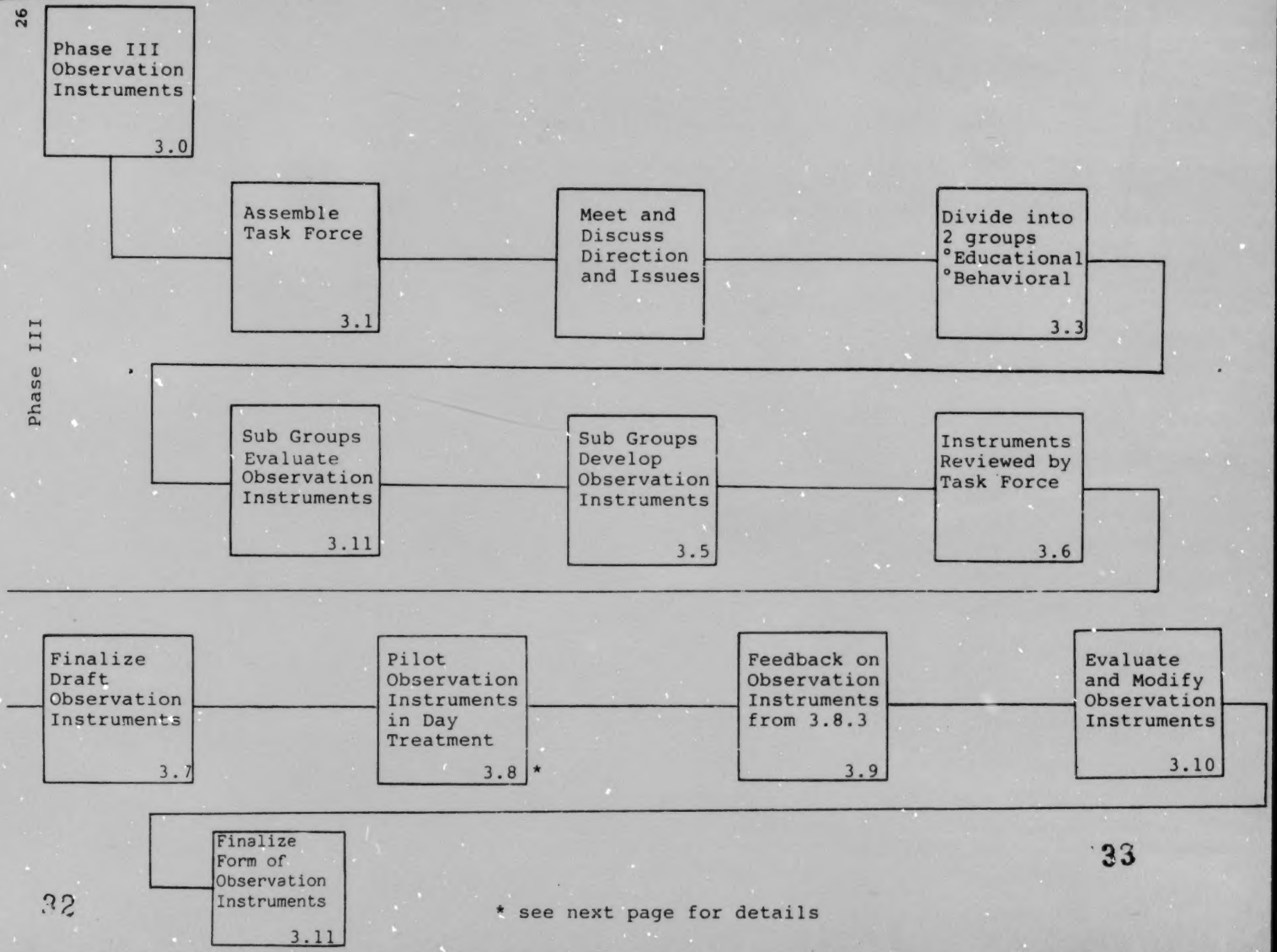
Phase II


Phase II Educational/ Behavioral Goals and Objectives Handbook 2.0
Determine Task Force Membership 2.1
Meet and Discuss Direction and Issues 2.2
Divide Task Force into Two Groups °Educational °Behavioral 2.3
Sub Groups Review Issues and Other Examples of Goals and Objectives 2.4
Sub Groups Prepare Draft Goals and Objectives Material 2.5
Total Task Force Reviews Products of 2.5 2.6
Modify Goals and Objectives Developed 2.7
Finalize Draft Handbook 2.8
Pilot Handbook in Day Treatment Program 2.9 *
Evaluate and Modify Handbook based on 2.9 2.10
Finalize Completed Handbook 2.11

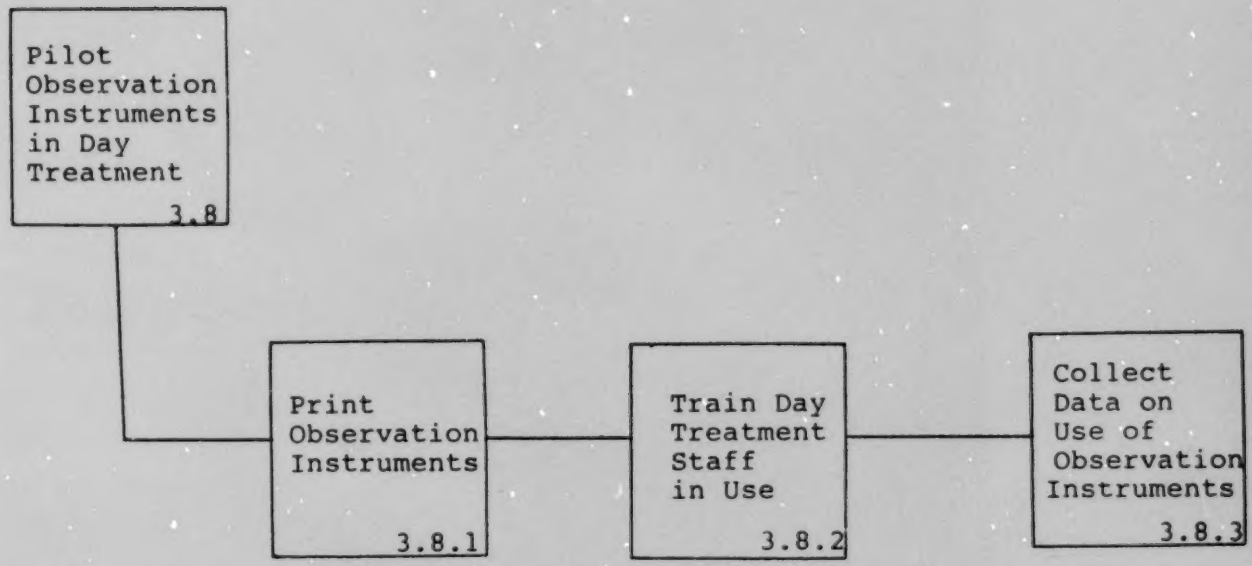
* see next page for details


Pilot Handbook in Day Treatment Program
2.9
Print Handbook
2.9.1
Train Day Treatment Staff in Use
2.9.2
Feedback for Use in 2.10
2.9.3

Phase III


Phase III Observation Instruments 3.0
Assemble Task Force 3.1
Meet and Discuss Direction and Issues
Divide into 2 groups °Educational °Behavioral 3.3
Sub Groups Evaluate Observation Instruments 3.11
Sub Groups Develop Observation Instruments 3.5
Instruments Reviewed by Task Force 3.6
Finalize Draft Observation Instruments 3.7
Pilot Observation Instruments in Day Treatment 3.8 *
Feedback on Observation Instruments from 3.8.3 3.9
Evaluate and Modify Observation Instruments 3.10
Finalize Form of Observation Instruments 3.11

* see next page for details


Pilot Observation Instruments in Day Treatment
3.8
Print Observation Instruments
3.8.1
Train Day Treatment Staff in Use
3.8.2
Collect Data on Use of Observation Instruments
3.8.3

INDIVIDUAL THERAPEUTIC AND EDUCATIONAL PROGRAM

PHASE I

COMMITTEE MEMBERS

Susan Avery, Supervisor
Program for Emotionally Handicapped,
Severely Emotionally Disturbed Students
Pinellas County Schools
1895 Gulf-to-Bay Blvd.
Clearwater, FL 33515

Anne Benedini, Supervisor
Specific Learning Disabilities and
Emotionally Handicapped
Pasco County District School Board
2609 Highway 41 North
Land 'O Lakes, FL 33539

Elaine Cutler, Staffing Supervisor
Pinellas County Schools
Area II Staffing Office
9099 118th Avenue North
Largo, FL 33543

Michael Fitzgerald, M.S.W.
Pinellas Young People's Residential
Treatment Homes, Inc.
1012 Jeffords Street
Clearwater, FL 33515

Julie Jackson, Supervisor
Psychological Services
Pasco County District School Board
2609 Highway 41 North
Land 'O Lakes, FL 33539

Betty Kjera, Ph.D.
Clinical Psychologist
16007 Chastain Road
Odessa, FL 33556

Karen Kuehn, Staffing Specialist
Pasco County District School Board
2609 Highway 41 North
Land 'O Lakes, FL 33539

Tom Lewis, Adolescent Day
Treatment Program
Mental Health Services Upper Pinellas
1437 South Belcher Rd., Suite 200
Clearwater, FL 33518

Michael Meredith, Behavioral Specialist
Pasco County District School Board
2609 High 41 North
Land 'O Lakes, FL 33539

Martha Simpson, Graduate Assistant
SED Network

Lee Sherry, Project Manager
SED Network

Michael Tomalesky, Program Coordinator
SED Network

Carol Violette, Training & Resource
Liaison
SED Network

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

Developed through a cooperative effort by Pasco and Pinellas County Schools and Mental Health Services.

- CONTENTS -

CHAPTER I:

STUDENT/CLIENT DEMOGRAPHIC INFORMATION

CHAPTER II:

EDUCATIONAL GOALS AND OBJECTIVES

CHAPTER III:

THERAPEUTIC GOALS AND OBJECTIVES

CHAPTER IV:

FORMS CHECKLIST

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

Chapter I

Student/Client Demographic Information

Name _____ D.O.B._____

Parent/Guardian _____

Address _____ Age_____

_____ Sex_____

Home Phone _____ Work Phone _____

I. Referral Information:

School/Program _____

Referred by _____ Referral Date _____

Referral Reason _____

_____

_____

Placed (date) _____ Program _____

II. Social History:

_____

_____

_____

_____

_____

_____

_____

Completed (date) _____ by_____

III. Psychological Data:

Completed (date)_____ by _____

IV. Psychiatric Data:

Medication: _____ Administered by _____

Completed (date) _____ by _____

V. Academic Data:

VI. Classroom/Program Observation Summary:

VII. Summary of Recommendations:

(social) _____

_____

(psychological) _____

_____

(psychiatric) _____

_____

(academic) _____

_____

VIII. Prognosis:

_____

_____

_____

_____

_____

IX. Contact Persons: (Case Management)

_____

_____

_____

_____

_____

X. Participation in Other Programs:

_____

_____

_____

_____

_____

_____

NOTIFICATION OF
SPECIAL EDUCATION GRADUATION REQUIREMENTS

Dear Parent/Guardian,

_____ has been placed in _____
(Student) (School Program)

to help him/her to maximize academic potential and affective growth. Recent educational requirements have changed the types and number of certain courses and standards necessary for receipt of a high school diploma. Due to your child's placement in the above special program, not all courses necessary for regular high school diplomas are offered.

Your child will receive credit for courses taken during his/her stay in the above program. He/she may not receive sufficient credit for certain courses necessary for graduation. However, your child may be eligible to receive a Special Diploma for participation in the exceptional education program. School and Day Treatment staff will work with you and your child to insure that as many courses as needed for graduation are completed before discharge. Your child may continue in regular or exceptional education after discharge from the program to complete courses necessary to meet general education graduation requirements. Please be informed that completion of the above program requirements does not guarantee completion of high school graduation requirements.

_____ _____
Parent/Guardian* Date

_____ _____
Student Name Date

_____ _____
Witness Date

* Signature does not indicate agreement with these statements. Signature does indicate that this information has been discussed with the Parent/Guardian.

If you have any questions please contact:

In Pinellas County
Department of Education for
Exceptional Students
1895 Gulf-to-Bay Blvd.
Clearwater, Fla. 33515
Telephone (813) 442-1171

In Pasco County
Exceptional Student Education
Pasco County District School
Board
2609 Highway 41 North
Land 'O' Lakes, Fla. 33539
Telephone (813) 996-3600

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

CHAPTER II

Educational Goals and Objectives

- CHECK LIST -

_____ Educational goals established

_____ Educational IEP completed/signed: Date: _____

_____ 1st 6/9 week Educational Goals/Objectives update*

_____ 2nd 6/9 week Educational Goals/Objectives update

_____ 3rd 6/9 week Educational Goals/Objectives update

_____ 4th 6/9 week Educational Goals/Objectives update

_____ 5th 6/9 week Educational Goals/Objectives update

_____ 6th 6/9 week Educational Goals/Objectives update

_____ Year end Educational Summary completed

Records forwarded to _____ on _____
School/Program Date

Approved by _____ on _____
Date

* Use with Program Plan Update Form

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

CHAPTER II

Educational Goals and Objectives

CHECKLIST OF OBTAINED SKILLS

TO BE DEVELOPED BY COMMITTEE IN

PHASE II

PRESS HARD OR TYPE

Pinellas County Schools

Department of Education For Exceptional Students

Individual Educational Plan

(1) Page _____ of _____

(2) ☐ INITIAL IEP ☐ UPDATE IEP

(3) DATE OF INITIAL IEP MO DAY YR _____

(4) LEGAL NAME OF STUDENT-LAST, FIRST MIDDLE	(5) DATE OF BIRTH	(6) STUDENT NUMBER	(7) CURRENT I.E.P. MEETING DATE MO DAY YR	(8) I.E.P UPDATE ON OR BEFORE MO DAY YR	(9) EXCEPTIONALITY(IES)	(10) GRADE

(11) PRESENT LEVEL OF EDUCATIONAL PERFORMANCE AND TEST INFORMATION: TO BE COMPLETED BY PERSON SENDING IN FOLDER

(12) OTHER INFORMATION:

(13) IS THIS STUDENT ELIGIBLE TO RECEIVE SPECIAL MODIFICATIONS DURING STATE ASSESSMENT TESTING ☐ YES ☐ NO

(14) EDUCATIONAL PROGRAMS AND SERVICES	(17) ANTICIPATED INITIATION DATE MO DAY YR	(18) ANTICIPATED DURATION DATE MO DAY YR	(19) RELATED SERVICES	(20) ANTICIPATED INITIATION DATE MO DAY YR	(21) ANTICIPATED DURATION DATE MO DAY YR
	MO DAY YR	MO DAY YR		MO DAY YR	MO DAY YR
	MO DAY YR	MO DAY YR		MO DAY YR	MO DAY YR
	MO DAY YR	MO DAY YR		MO DAY YR	MO DAY YR
	MO DAY YR	MO DAY YR		MO DAY YR	MO DAY YR
(15) PHYSICAL EDUCATION ☐ REGULAR ☐ ADAPTIVE	MO DAY YR	MO DAY YR		MO DAY YR	MO DAY YR
(16) HOURS MAY VARY ACCORDING TO THE NEEDS OF THE STUDENT					

(22) PARTICIPANTS IN THE I.E.P. MEETING

SIGNATURE - LEA REPRESENTATIVE	TITLE	MO DAY YR	SIGNATURE PARENT/GUARDIAN	TITLE	MO DAY YR
SIGNATURE - CASE MANAGER	TITLE	MO DAY YR	SIGNATURE	TITLE	MO DAY YR
SIGNATURE	TITLE	MO DAY YR	SIGNATURE	TITLE	MO DAY YR
SIGNATURE	TITLE	MO DAY YR	SIGNATURE	TITLE	MO DAY YR

METHOD OF PARENT NOTIFICATION FOR IEP UPDATE	BY WHOM (NAME AND TITLE)	MO DAY YR
(23) 1.		
METHOD OF PARENT NOTIFICATION FOR IEP UPDATE	BY WHOM (NAME AND TITLE)	MO DAY YR
2.		

PCS Form 108-1 (Rev 12-82)

Warehouse ID No. 98207

PART 1 - PARENT PART 2 - STAFFING TEAM FILE PART 3 - DFES TEACHER PART 4 - ASST. SUPT. FOR DEES PART 5 - ADDITIONAL SERVICE

36

PRESS HARD OR TYPE

Pinellas County Schools

Department of Education For Exceptional Students

Individual Education Plan: Annual Goals and Short Term Objectives

(24) PAGE ___ OF ___

INSTRUCTIONS: STAPLE TO PAGE 1 OF THE INDIVIDUAL PLAN PCS FORM 108.1. YOU MAY REFERENCE SPECIFIC OBJECTIVES TO PROFILE SHEETS, INDIVIDUAL STUDENT RECORDS AND SPECIFIC SUBJECT AREA OBJECTIVES

(25) EVALUATION PROCEDURE CODE
CRT - Criterion Referenced Testing
ST - Standardized Test
SE - Self Evaluation
TO - Teacher Observation
SP - Student Product
PE - Peer Evaluation
CL - Checklist

(26) LEGAL NAME OF STUDENT LAST, FIRST, MIDDLE	(27) EXCEPTIONALITY(IES)	(28) NAME OF DEES TEACHER(S)	(29) VALIDITY PERIOD MO DAY YR TO MO DAY YR

(30) GOAL: / (31) OBJECTIVE:	(32) INITIATION DATE MO DAY YR	(33) *COMPLETION DATE MO DAY YR	(34) EVALUATION PROCEDURE
OBJECTIVE:			
OBJECTIVE:			
GOAL:	INITIATION DATE MO DAY YR	*COMPLETION DATE MO DAY YR	EVALUATION PROCEDURE
OBJECTIVE:			
OBJECTIVE:			
GOAL:	INITIATION DATE MO DAY YR	*COMPLETION DATE MO DAY YR	EVALUATION PROCEDURE
OBJECTIVE:			
OBJECTIVE:			
GOAL:	INITIATION DATE MO DAY YR	*COMPLETION DATE MO DAY YR	EVALUATION PROCEDURE
OBJECTIVE:			
OBJECTIVE:			
GOAL:	INITIATION DATE MO DAY YR	*COMPLETION DATE MO DAY YR	EVALUATION PROCEDURE
OBJECTIVE:			
OBJECTIVE:			
GOAL:	INITIATION DATE MO DAY YR	*COMPLETION DATE MO DAY YR	EVALUATION PROCEDURE
OBJECTIVE:			
OBJECTIVE:			

PART 1 - PARENT PART 2 - STAFFING TEAM FILE PART 3 - DEES TEACHER PART 4 - ASST SUPT FOR DEES PART 5 - ADDITIONAL SERVICE * SEE TEACHERS WORK FILE

DISTRICT SCHOOL BOARD OF PASCO COUNTY: EXCEPTIONAL STUDENT EDUCATION
INDIVIDUAL EDUCATIONAL PLAN

MIS Form #727
Revised 7/82

(1) Student Name _____
(2) D.O.B. _____
(3) Student ID# _____

	Month	Year
(4) Original IEP Date		
(5) Current IEP Date		
(6) IEP Review Date		
(7) Formal Re-evaluation Due Date		

(8) IEP Revisions

Month	Year

EXCEPTIONAL EDUCATION ASSIGNMENTS

(9) Program Name(s)	(10) Program Location(s)/Grade	(11) Anticipated Initiation Date of Services Month	Day	Year	(12) Anticipated Duration of Services for this IEP Month	Year

(13) RELATED SERVICES

Type(s)	Location(s)	Anticipated Initiation Month	Day	Year	Anticipated Duration Month	Year

(14) Special Transportation Required ____Yes ____No

EXTENT TO WHICH STUDENT WILL PARTICIPATE IN EDUCATIONAL PROGRAMS:

(15) Regular Subjects	Hours/Wk	(16) ESE Subjects	Hours/Wk
P.E.			
Vocational			

(17) Use of Basic (Double) Cost Factor: Basic Class(es)
NOTE: MUST BE APPROVED BY ESE DIRECTOR

Use of Funds (specify Special Equipment, Materials, Service)

ESE Director Signature

(18) IN ATTENDANCE AT IEP MEETING: Signature	Date	(19) REVISION 1 Signature	Date	REVISION 2 Signature	Date
LEA Representative (Title ___)					
Parent(s), Guardian(s)					
Student (as appropriate)					
Teacher/Program					
Teacher/Program					
Teacher/Program					
Evaluator(s)					
Other					
Principal/Asst.					

SEE BACK FOR INSTRUCTIONS

DISTRIBUTION: White: Cumulative Folder Canary: Program Pink: Parent

PASCO COUNTY SCHOOL DISTRICT'S EXCEPTIONAL STUDENT EDUCATION INDIVIDUAL EDUCATIONAL PLAN: page 2

PERFORMANCE OR SUBJECT AREA:

Student Name_____

PRESENT LEVEL:

ANNUAL GOAL:

SHORT-TERM INSTRUCTIONAL OBJECTIVES	EVALUATION OF SHORT-TERM INSTRUCTIONAL OBJECTIVES		
	Criterion for Mastery	Evaluation Procedures and Schedule to be used	Results/Date

cum - white
program - canary
parent - pink

NOTE: update every 6/9 weeks

PROGRAM PLAN UPDATE

_____ to _____

Student/Client _____ Page _____

Teacher/Clinician _____ CHAPTER II or III Program _____

Date _____

- OBJECTIVES -

Annual Goal	Short Term Objective	Evaluation Procedures, Criteria & Schedule	Date of Evaluation	Mastery Yes/No	Recommendation	Signature

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

CHAPTER III

Therapeutic Goals & Objectives

- CHECK LIST -

_____ Initial Treatment Plan (cover sheet) completed _____ Date

_____ 1st set Long and Short Term Objectives completed

_____ 1st 6/9 week review and update

_____ 2nd 6/9 week review and update

_____ 3rd 6/9 week review and update

_____ 4th 6/9 week review and update

_____ 5th 6/9 week review and update

_____ 6th 6/9 week review and update

_____ Year end therapy summary completed

Termination Summary _____ Date

Completed by _____

Termination Summary sent to _____ School/Program on _____ Date

Approved by _____ on _____ Date

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

CHAPTER III

Therapeutic Goals and Objectives

CHECKLIST OF OBTAINED SKILLS

TO BE DEVELOPED BY COMMITTEE IN

PHASE II

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

CHAPTER III

Therapeutic Treatment Plan

- COVER SHEET -

Name	Program	Date	Date First Update Due

1. Psychiatric Problems (include chief complaint and physical problems) (Use behavioral terms.)

2. Social Problems (include vocational, educational, legal, family)

3. Client Strengths and Assets

4. Tenative Discharge Plan (Includes treatment after discharge, school program placement, consider all alternatives.)

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

CHAPTER III

Therapeutic Treatment Plan

-OBJECTIVES-

NOTE: Indicate anticipated level of involvement of parent(s) in the therapeutic process in either the long or short term goals or objectives.

Page _____

Name _____ Date _____ Date of Next Review _____

Long Term Goal:	Expected Date Of Achievement	Plan
		(Physician) (Date)
Short Term Objectives:		
		Signature

Signature (Clinician) Date

Title

Signature (Client) Date

Signature (Parent) Date

NOTE: update every 6/9 weeks

PROGRAM PLAN UPDATE

_____ to _____

Student/Client _____

Teacher/Clinician _____

Date _____

CHAPTER II or III

Page _____

Program _____

- OBJECTIVES -

Annual Goal	Short Term Objective	Evaluation Procedures, Criteria & Schedule	Date of Evaluation	Mastery Yes/No	Recommendation	Signature

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

CHAPTER III

Clinical Closing Summary

Client Name _____

1. Reason for Initial Contact:

2. Problems Presented:

3. Frequency of Contacts:

4. Treatment & Goal:

5. Result of Treatment:

6. Reason for Closing:

7. Follow up Plan:

8. Date of Last Contact: _____

Primary Therapist _____
Signature/Date

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

CHAPTER III

NOTE: All therapeutic summaries will include the following information. Clinical notes are not to be sent with Educational information.

Termination Summary (format)

I. IDENTIFYING CHARACTERISTICS:

A. Name:
B. File Number:
C. Date of Termination:

II. ADMISSION CHARACTERISTICS:

A. Referral Source:
B. Date of Admission:
C. Referral Problem:

III. PROGRAM TREATMENT RESULTS:

A. Identified Problems:
   1. Problem One
      a. Description of Problem One
      b. Treatment/Disposition of Problem One
      c. Outcome
         i. Significantly improved (problem substantially alleviated)
         ii. Improved (some alleviation of problem)
         iii. No Change/Deterioration
      d. Initial Problem Severity
         i. Acute/mild
         ii. Moderate
         iii. Severe/chronic
      e. Intervention Effect (Outcome x Severity)
         i. Marked
         ii. Moderate
         iii. Little
   2. Problem Two (Same as Problem One Above)
   3. Problem Three (Same as Problem One and Two Above)
B. Goal Attainment (average all intervention effects)
C. Number of Contacts
D. Date of Last Contact
E. Termination Status
   1. Treatment plan completed, or,
   2. Left during treatment, or,
   3. No further services required

IV. IMPRESSION:
A. Final Diagnosis
B. Recommendations
C. Referrals (note if referral source was apprised of client's termination)

V. THERAPIST'S SIGNATURE: _____ _____
Title Date

INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

Chapter IV

FORMS CHECKLIST

_____Parent/Guardian Permission for Testing _____
Date

_____Parent/Guardian Permission for Information Release _____
Date

_____Parent/Guardian Permission for Information Request _____
Date

_____Consent to Treatment _____
Date

_____All Staffing Forms and Signatures Completed _____
Date

_____County's IEP Completed and Signed _____
Date

_____School/Program Registration Form _____
Date

_____Transportation _____
Date

_____Video Tape Permission _____
Date

_____Field Trip Permission _____
Date

_____Lunch Program Application _____
Date

PROCEDURES MANUAL

INDIVIDUAL THERAPEUTIC AND EDUCATIONAL PROGRAM

The Individual Therapeutic and Educational Program represents a major effort among education and mental health professionals to jointly develop comprehensive treatment and educational plans for severely emotionally disturbed students. The ITEP documentation system is the product of a multiagency process. The ITEP format provides a storage place for plans, goals and objectives for students in Day Treatment programs.

The ITEP document is divided into four color coded chapters:

- Student/Client Demographic Information (Goldenrod)
- Educational Goals and Objectives (Goldenrod)
- Therapeutic Goals and Objectives (Blue)
- Form checklist (Green)

Each chapter is a separate storage system for information related to planning and implementation of the individual child's educational and therapeutic program. Together, the four chapters describe the complete program for the child. It is anticipated that education and mental health professionals will work as a single team to develop each child's academic and therapeutic program. The ITEP will be housed in a separate notebook for each child. It will serve as a ready reference guide to the student's progress in achieving all goals and objectives.

The chapter format was developed by the multiagency task force to:

- Enhance record keeping efficiency
- Guarantee student/client confidentiality
- Provide a comprehensive individualized educational and therapeutic program implementation plan

The ITEP provides a single storage system for all placement, planning, and program implementation information. All staff have access to each child's program for review purposes. In addition, the chapter format assists education and mental health professionals in retrieval of the specific implementation plans for which they are primarily responsible.

STUDENT/CLIENT CONFIDENTIALITY

One goal of human service professionals is to protect the rights of the student/client while offering the benefit of specialized services. To guarantee the confidentiality of information and to adhere to both mental health and public education rules the multiagency task force recommended the chapter format.

The following requirements were reviewed:

- Chapter 394--Florida Mental Health Act
- Chapter 10E-4 and Chapter 10E-10 Rules of State of Florida Department of Health and Rehabilitative Services
- Chapter 6A-6 Florida State Board of Education Administrative Rules

Comparison of these Education, Mental Health, and Health and Rehabilitative Services rules concerning student/client confidentiality revealed many similarities in the content and intent of those rules. Education and mental health professionals are guided by different sets of Florida Statutes, however, the statutes essentially contain the same mandates assuring confidentiality of children's rights.

In the daily use of the ITEP, there are no constraints placed on educators and mental health professionals who are members of the same service team. Both groups of professionals may share and review all pertinent data relevant to the implementation of educational and therapeutic services. Access to the ITEP document is not restricted during the time the child remains in a program.

Confidential record keeping becomes an issue when the child leaves a program either by discharge, attrition, or placement in another program. When the child leaves the program, the question of transfer of records becomes an issue. Two major questions arise. Which records remain? Which records are transferred?

State Board of Education Rules require local education agencies to transfer all student records to the receiving school or program. Mental Health Rules require that treatment plans not be transferred because of their clinically sensitive nature. However, a treatment summary may be forwarded to a new or receiving program.

The color coding of the ITEP chapters designates which information may be transferred and which information must be retained when a child leaves the program. Information in Chapter II, Educational Goals, and Objectives (goldenrod) may be transferred. The treatment plan, Chapter III, Therapeutic goals and Objectives (blue) must not be transferred but must be summarized on the Termination Summary (goldenrod).

TRANSFERABLE INFORMATION

Pages in the goldenrod color represent information that is transferable and should be part of the child's regular cumulative folder. The following sections are goldenrod in color:

- Chapter I: Student/Client Demographic Information
- Chapter II: Educational Goals & Objectives Checklist - Cover sheet
  Educational Goals & Objectives Checklist of Obtained Skills
  Individual Educational Plan pages 1 & 2
  Program Plan Update
- Chapter III: Termination Summary

NON-TRANSFERABLE INFORMATION

Pages in blue are retained by the Mental Health Agency participating in the program and form the basis of the Mental Health treatment plan. Pages in blue include:

° Chapter III: Therapeutic Goals and Objectives Checklist
Therapeutic Goals and Objectives Checklist of Obtained Skills
Therapeutic Treatment Plan Objectives
Program Plan Update
Clinical Closing Summary
Termination Summary (copy)

Chapter IV is for storage and consists of a checklist of forms needed to comply with local agency rules and program needs. These forms are divided according to their content, i.e., Education or Mental Health, and may be transferred or retained depending on the topic of the form.

The ITEP task force also explored the cooperative development of educational and therapeutic goals and objectives for each child by the team of teachers and Mental Health professionals. The ITEP concept promotes the equal sharing of educational and clinical information to be used in developing both educational and therapeutic goals and objectives. The ITEP is a means of promoting the multidisciplinary team approach to treatment of severely emotionally disturbed children.

USING THE ITEP DOCUMENTATION SYSTEM

Chapter I: Student/Client Demographic Information (Goldenrod)

These three pages serve as a quick summary reference of information collected to diagnose and place the child in the program. This information will be summarized on the forms by the Staffing Specialist after the child has been accepted into the program. In the event the Staffing Specialist is unable to complete the forms, a designated program person will complete this section.

PAGE ONE

Name and Address: self-explanatory

I. Referral Information: Serves as background prior to Program placement.

II. Social History: Relevant points or aspects of child's background, especially information that relates to child's emotional dysfunction.

PAGE TWO

III. Psychological Data: Relevant psychological test scores and summary of recommendation made by psychologist.

IV. Psychiatric Data: Brief summary of psychiatric evaluation. Highlight diagnosis and recommendations. List number, types, and frequency of administration of medications prescribed and who may administer them.

V. Academic Data: Relevant up-to-date academic testing. List recommendations for curriculum.

VI. Classroom/Program Observation Summary: Report most revealing behavior from observations made of child in previous programs or other settings.

PAGE THREE

VII. Summary of Recommendations: List by category, recommendations most relevant to placement of child in the program.

VIII. Prognosis: Based on recent information taking into account social, psychological, psychiatric and other information. Estimate level of expected success and anticipated length of time in the program.

IX. Contact Persons: List professionals who have contributed to the placement decision or who have an ongoing contact or knowledge of the child.

X. Participation in other Programs: List programs other than the one from which the child is being referred. Highlight whether the child was successfully discharged and recommendations made by the program.

NOTIFICATION OF SPECIAL EDUCATION GRADUATION REQUIREMENTS

This is a letter of information for the parents and/or guardians of the child being staffed into the program.

Recent State Department of Education assessments of high school graduation requirements may potentially effect the number and types of credit high school aged Special Education students may require for receipt of a regular High School Diploma. This letter, on NCR paper, will inform parents of these possible changes in requirements. The parent will receive the first, signed copy. The second duplicate page will remain in the file.

During the staffing of the child into the program, the Staffing Specialist will explain the intent of this letter and seek parents' signature. This letter, as noted, does not denote acceptance of its content. Parent signature only indicates that they have been informed.

Chapter II: Educational Goals and Objectives

The first page of Chapter II is a checklist of activities that are maintained on a regular basis. This page serves as a ready reference to activities completed for each child. Should the child leave the program, this page also serves as a cover sheet to the (goldenrod) Transferable Information. Records forwarded to: (name of program or school), date and approval to send will be recorded on this page.

Checklist of Obtained Skills:

This checklist (developed in Phase II) will serve as a quick reference to the child's mastered and unmastered Educational Goals and Objectives. The checklist also serves as additional documentation of the child's skills, strengths, weaknesses and areas that need improvement. This checklist will be used in conjunction with the Educational and Behavioral Goals and Objectives Handbook.

Individual Education Plan:

Storage of approved IEP forms is available in this location of the IEP Document. Reference to school systems district procedures will outline the proper use of these documents. Whenever possible, the long range Goals and Objectives set forth in the IEP will be taken from the Educational and Behavioral Goals and Objectives Handbook. Appropriate signatures will be necessary. Update of these IEP forms will be annually as defined in the school's district procedures.

Program Plan Update (Chapter II):

This form truely represents the "working document" concept of the IEP. Minimum update times is six (6) or nine (9) weeks depending on the grading period of the program. This form serves as a working, planning sheet to outline specific objectives to be mastered by the child. The following are specific areas on the form:

Annual Goal:

Reference to IEP form for listing of general goals.

Short-Term Objectives:

When possible, pulled from Educational and Behavioral Goals and Objectives Handbook. May be further defined with specific steps or categories of accomplishment.

Evaluation Procedures, Criteria and Schedule:

How is the objective to be evaluated? What criteria of success is chosen? When shall behavior (etc.) be demonstrated (time frame)?

Date of Evaluation:

Record date that objective was evaluated as defined in evaluation procedure. Each objective should be evaluated within a minimum of six (6) week periods.

Mastery, Yes/No:

Has child mastered skill? Record mastery of skill: yes ___ no ___.

Recommendation:

If the child has mastered the skill, what is recommended next? If child has not mastered skill, what is the plan: continue for more time, drop objective, re-evaluate or reduce criteria for successful completion of objective?

Signature:

Person receiving or completing row of information should "sign off." Initials are sufficient.

Chapter III: Therapeutic Goals and Objectives

The first page of Chapter III is conceptually a duplicate of page one, Chapter II. The checklist is used the same as the form in Chapter II. In addition, termination summary completion date should be indicated as well as who completed the form.

Checklist of Obtained Skills:

This form is conceptually similar to that in Chapter II. The behavioral goals and objectives developed in Phase II are based on a hierarchy of normally acquired behavioral skills. The checklist will serve as ready reference to the child's obtained and needed skills. In addition, the Handbook of Educational and Behavioral Goals and Objectives will be the main source of behavioral goals and objectives for the staff to use in developing the individual plan.

Therapeutic Treatment Plan:

Cover Sheet: This sheet will be completed within 72 hours of the child entering the program. The Cover Sheet consists of four major categories of information.

1. Psychiatric Problems: a summary of problems which are identified as major sources of the child's emotional dysfunction. The problems should be defined in behavioral terms whenever practical. Usually the program's psychiatrist, psychologist or mental health counselor will respond to this section.

2. Social Problems: information relevant to the child's dysfunction including educational, legal, and family background. Vocational skills, if any, should be noted.

3. Client Strengths and Assets: strengths upon which child may draw for improvement in emotional/social condition should be listed. Strengths or assets may be: family, peers and/or social groups. Personal strengths such as above average intelligence or other skills that can be used to improve the child's emotional condition are noted.

4. Tentative Discharge Plan: list anticipated placements and/or after-care in programs, that will benefit child's emotional development. Also anticipated placement if program is not meeting child's needs. This section forms the beginning of the after-care planning process.

Objectives:

This form represents the Mental Health Treatment Plan form. The information contained on this form meets Mental Health regulations necessary to form a clinical record of the child's therapy in the program.

The long-term goal section should be specific enough to make planning a short-term objective as easy as possible. The psychiatrist or psychologist associated with the program should participate in the development of the long-term goals. Expected date of achievement and the plan should be specific to achieving the goal. Usually this section of the record will be completed within the first 30 days of the child's stay in the program.

Short-Term Objectives should be defined by using the team process including teacher and Mental Health staff input. Signature of person completing objective is required. To comply to Mental Health regulations, the client/or client's parent or guardian will sign the Treatment Plan form. The processing clinician will also, after reviewing the plan with the client, sign the form.

Program Plan Update (Chapter III):

This page is a duplicate of Chapter II's Program Plan Update form. Further definition of short-term therapeutic objectives may be made on this form. The form may be updated continually but will be reviewed every grading period, e.g., six (6) and/or nine (9) weeks.

Clinical Closing Summary:

This is a generic Closing Summary form typically used in Mental Health Clinical records. It is included in the ITEP to complete the Mental Health Clinical record.

1. Client's name: first, last.

2. Reason for initial contact: summary of reason for child's placement in the program.

3. Problems presented: presenting problems and summary of further defined problems during stay in program.

4. Frequency of contacts: in the Day Treatment program, daily contact is anticipated. Note other specialized contact with child or family.

5. Treatment and Goal: major treatment goal summary of treatment plan. Due to motive of ITEP Documentation system, details of this information are available elsewhere in the file.

6. Result of Treatment: measure of effectiveness of child's stay in program. Notable improvement or changes in child's emotional condition.

7. Reason for Closing: note why child has left program. Successful discharge or attrition from program for stated reasons.

8. Follow-up Plan: specify where child is going after discharge (school, another program, special education, etc.). If child leaves program before completion, note anticipated placement.

9. Last Date of Contact: specify date that the child or family was seen last or contacted for information before closing case.

Primary therapist will sign and date this report.

Termination Summary:

The Termination Summary is to be completed by the Mental Health primary therapist with input from other program staff. The summary should follow the outline but be sufficiently detailed to explain the child's progress in the program. Since all blue Mental Health forms will be retained in the Mental Health clinical record, the Termination Summary represents the only documentation accompanying the child's cumulative record. The Termination Summary outline (goldenrod color) indicates that the information is transferable.

Chapter IV: Forms Checklist

Chapter IV is a storage area in the ITEP document (notebook) for permission documents and other forms necessary for placement and continuation of the child in the program. When the child leaves the program, copies of originals of educational forms will be placed in the cumulative record. Mental Health oriented forms will remain with the Mental Health Clinical record.

INDIVIDUAL THERAPEUTIC AND EDUCATIONAL PROGRAM

Documentation System

IMPLEMENTATION PLAN

	Activity	Date
I.	Review ITEP Forms - correct as necessary	12/5/83
II.	Order notebooks for Day Treatment Piloting of ITEP	12/6/83
III.	Make up notebooks by ITEP Chapters (copy forms, printing reserved for future editions)	When notebooks arrive
IV.	Develop feedback system for Day Treatment staff to respond to initial use of ITEP Forms. (Material mailed to Mary Ellzey for consultation on system development)	Mailed information 12/5/83 Develop 12/5/83 - 1/16/84
V.	Develop training module to orient Day Treatment staff to use of ITEP Forms	12/7/83
VI.	Review training module with Training & Resource Liaisons. They will present module to Day Treatment staff.	12/15/83
VII.	Schedule training sessions with Day Treatment staffs. (Training & Resource Liaison will schedule)	1/2/84
VIII.	Orientation Presentation to Day Treatment staffs. (Distribute materials - notebooks, Procedure Manual)	1/9 - 23/84
IX.	Begin use of ITEP documentation system in Day Treatment Program	1/24/84
X.	Feedback system distributed	5/7/84
XI.	Feedback system forms returned	5/31/84

SED NETWORK
INDIVIDUAL THERAPEUTIC & EDUCATIONAL PROGRAM

Phase II
Task Force

Chairperson: Michael Tomalesky, Program Coordinator

BEHAVIORAL GOALS/OBJECTIVES

Chairperson: Lee Sherry, Project Manager

Michael Bessette - Assistant Principal, Richard L. Sanders School

Maureen Gale - Training & Resource Liaison

Michael Fitzgerald - Licensed Clinical Social Worker, Clearwater

Len Kizner - Staffing Supervisor, Area III

Betty Kjera - Licensed Clinical Psychologist, Tampa

Tom Lewis - Team Leader ADTP, Mental Health Service Upper Pinellas, Inc.

Tom McDevitt - Mental Health Specialist, ADTP, Pasco County

Michael Meredith - Behavior Specialist, Moon Lake Elementary, Pasco County

Janet Peck - ADTP, Safety Harbor Exceptional Student Center

Angelo Vicario - Guidance Counselor, Safety Harbor Exceptional Student Center

EDUCATIONAL GOALS/OBJECTIVES

Chairperson: Carol Violette, Training & Resource Liaison

Kathy Black - Specific Learning Disabilities (SLD) Program, Pinellas County

Gayle Curtis - Severely Emotionally Disturbed (SED) Teacher, Moon Lake Elementary, Pasco County

Suzan Mullins - Resource Teacher Emotionally Handicapped/Severely Emotionally Disturbed (EH/SED) Program

Mary Rasor - Emotionally Handicapped (EH) Teacher, Largo High School

Teresa Shelley - Severely Emotionally Disturbed (SED) Teacher, Safety Harbor Exceptional Student Center, Pinellas County

Debbie Simpson - Supervisor, Florida Diagnostic Learning & Resource System (FDLRS)

Linda Splawn - Severely Emotionally Disturbed (SED) Teacher, Richard L. Sanders School

Dorothy Wice - Specific Learning Disabilities (SLD) Teacher, Pinellas County

VIDEO TAPE ACTIVITY

DATA COLLECTION PROPOSAL

Prepared by:

Dave Riordan, Teacher
Adolescent Day Treatment Program
School Board of Pinellas County, Florida/
Mental Health Services of Upper Pinellas County, Inc.

Maureen Gale, Training and Resource Liaison
SED Network

Lee Sherry, Project Manager
SED Network

Bob Algozzine, Consultant
Department of Special Education
University of Florida

January 25, 1984

I. INTRODUCTION

It is proposed that a video tape data collection procedure be implemented to assess the effects of video tape activities in the classroom for SED adolescents. To accomplish this task a study will be conducted in two therapeutic/educational environments serving SED students. These two settings are (1) Richard L. Sanders School and (2) the Adolescent Day Treatment Program (ADTP) located at Mental Health Services of Upper Pinellas County , Inc. The ADTP is a therapeutic/educational program jointly operated by the School Board of Pinellas County and Mental Health Services of Upper Pinellas County, Inc. Richard L. Sanders School is a center for severely emotionally disturbed students in the Pinellas County schools. The proposed study will incorporate the use of three groups of students from the Sanders School and one group of students from the ADTP located at Mental Health Services of Upper Pinellas County, Inc. The data collection methods and procedures includes three phases. These phases are: (1) pre-test data collection, (II) intervention, and (III) post-test data collection. Results of this study will be available for review by the SED Network Evaluation Consortium and the SED Network Advisory Committee. In addition, results will be submitted, in manuscript form, to nationally recognized journals in the fields of education and psychology.

II. RATIONALE

Prevalence figures published by the Bureau of Education for the Handicapped (BEH) indicate that approximately 0.5% of individuals between the ages of 3-21 would require special education services because of severe emotional problems. As more students are identified and certified as SED in the Pasco/Pinellas area it becomes imperative to provide an educationally and therapeutically sound program for these students.

The Pinellas County Schools Department of Education for Exceptional Students Program for Emotionally Handicapped Students Task Force Report (1979-80) recommends three basic components for a successful program for emotionally disturbed students. These components are:

1. description of priority goals and methods designed to bring about desired behavioral changes,

2. utilization of a wide variety of techniques for controlling inappropriate behavior and building coping skills, and

3. provision of support and intervention to create greater understanding of individual student needs.

A program such as this requires the cooperative efforts of teachers, principals, students, parents, administrators, educational support personnel, mental health professionals, higher education and social services providers to assure that the needs of this population are met.

Following the directives of the Task Force Report and Pilot Project goals/objectives, the SED Network has been charged with the task of improving the quality of existing services and diffusion of best practices and procedures for use with SED students. To accomplish the goal of improving existing therapeutic techniques SED Network staff under the guidance of the SED Network Advisory Committee have developed several activities.

One of these activities is the use of video tape in the classroom for severely emotionally disturbed students. Planning of this activity occurred by involving mental health and school based personnel. A brief summary of each planning meeting is listed below:

1. July 27, 28, 29 - A planning meeting with Maureen Gale, Training and Resource Liaison and Dave Riordan, ADTP classroom teacher was held. The video tape activity training module and student activities were outlined during this three day planning session.

2. August 2 - A proposed evaluation plan was developed with Maureen Gale, Training and Resource Liaison, Dave Riordan, ADTP classroom teacher, Bob Algozzine, Consultant, University of Florida, and Lee Sherry, Project Manager. The evaluation procedure was divided into three major areas: (1) Staff Development, (2) Data Collection, and (3) Training Module Evaluation.

3. August 3 - A timeline was developed outlining the process necessary to accomplish data collection during 1983 and development of the video tape activity training module during 1984.

4. August 5 - The video tape activity component to be included in the 1984 SED Network project proposal was developed.

5. August 16 - The video tape activity plan was presented to the SED Network Advisory Committee by Maureen Gale, Training and Resource Liaison. An updated memorandum was distributed to the Advisory Committee members listing completed activities related to this project. Projected activities were also listed including:

   a. Development of a comprehensive literature review. This review will describe role play, psychodrama, and video tape activities,

   b. Development of the video tape activity data collection proposal, and

   c. Projected 1984 video tape activities. These projected 1984 activities include:

      (1) Development of a Training Module,

      (2) Development of staff inservice activities, and

      (3) the information dissemination process.

6. August/September - A comprehensive literature review was completed and summarized. It has been included in the Video Tape Activity Data Collection Proposal. The Data Collection Proposal (draft) was completed. The proposal included (a) Rationale, (b) Literature Review, and (c) Methods and Procedures.

7. September 20 - The video tape activity data collection proposal (draft) was presented to the SED Network Advisory Committee for review and approval by Maureen Gale, Training and Resource Liaison. The proposal (draft) was discussed and approved by the Advisory Committee.

8. September 23 - A meeting was held with Maureen Gale, Training and Resource Liaison and Bob Algozzine, Consultant, University of Florida to review the video tape data collection proposal (draft). During this meeting the methods and procedures section of the proposal, including Phases I, II, and III, were discussed and additional information generated. Specifically, the pre- and post-test data collection instruments were outlined.

9. October - The video tape activity data collection proposal was updated to include information generated during meetings held during August/September. Data collection instruments were developed and will be submitted to the Evaluation Consortium for review.

10. November 15 - The revised data collection proposal was presented to the SED Network Advisory Committee by Maureen Gale, Training and Resource Liaison as an update of this activity. (Included in this update was the rationale for delaying data collection until January, 1984.)

11. November 28 - The data collection proposal was presented to the following people for review and approval:

    a. Craig Anderson, Principal, Richard L. Sanders School;
    b. Phyllis Cloman, Supervisor, Mental Health Services of Upper Pinellas County, Inc.;
    c. Susan Avery, Supervisor Program for Emotionally Handicapped and Severely Emotionally Disturbed Students;
    d. Jean Evans, Director, Children's Services, Mental Health Services of Upper Pinellas County, Inc.

    Maureen Gale, Training and Resource Liaison, Lee Sherry, Project Manager and Dave Riordan, ADTP Classroom Teacher presented the proposal. The proposal was approved.

12. December/January - During this time Data Collection instruments utilized in the study were submitted to the Evaluation Consortium for review and approval. Revisions were completed as suggested. The Data Collection Instruments were approved.

13. December 15 - The Pinellas County Schools Research Proposal Request was completed and submitted to Alan Mortimer, Director, Research and Planning, Pinellas County Schools. The Research Proposal Request was completed by Maureen Gale, Training and Resource Liaison and Lee Sherry, Project Manager. Approval pending notification.

14. December 16 - Teachers participating in the study were identified and notified of training dates, times, and location. A memorandum was sent by Lee Sherry, Project Manager and Craig Anderson, Principal, Richard L. Sanders.

15. January 4-5, 1984 - A meeting was held with Maureen Gale, Training and Resource Liaison, Lee Sherry, Project Manager, and Bob Algozzine, Consultant, University of Florida. During this meeting (1) the data collection instruments were revised and finalized, (2) the teacher training procedures were outlined, (3) the data analysis procedures were outlined, and (4) Parent/Student Permission Forms were developed.

16. January - During the month of January classroom teachers will be trained as participants in the video tape data collection. (Training dates are January 11, 18, and 25.)

17. January 16 - The data collection process will begin on January 16, 1984 following teacher and observer training.

III. LITERATURE REVIEW

The review of the literature includes state-of-the art activities in three major areas. Described below are nationally recognized educational/ therapeutic techniques that support the concept of video tape activities. They include: (1) role play, (2) psychodrama, and (3) video tape activities for use with exceptional students.

Role Play

Role play is often used in the therapeutic process. The basic tenent of role play is that therapeutic outcomes can be enhanced through its proper use (Miller, 1980). Role play, a direct action oriented approach, is based on the concept that learning occurs by doing. It allows participants to try out and discover new behaviors, new solutions, and bring life into events that are performed in the classroom. These activities help the student practice appropriate behaviors in a non-threatening situation. Miller (1980) defines role play as the acting out of a set of behaviors that depict a person "as is" or as he or she wishes to become.

Role play activities can provide students with the opportunity to internalize the idea that they have control over their own actions and reactions (Miller, 1980). Role play as an intervention for maladaptive classroom behavior has been cited in the literature as a successful strategy (Miller, 1980). However, empirical research has been limited by numerous methodological problems. These problems include (1) inappropriate measures of performance, (2) lack of reliability of measures of performance, and (3) lack of follow-up and/or generalization of students' behaviors following intervention (Lebsock & Salzberg, 1981).

Although research on the effect of role play in the classroom and/or therapeutic environment is limited, benefits of this technique have been reported. Several sources suggest that the benefits of role play include the opportunity for students to (1) learn social skills, (2) receive feedback on maladaptive behavior, (3) discover effective methods for confronting people and life events, (4) change their attitudes, and (5) reduce anxieties associated with specific situations (Miller, 1980). Role play has proven to be a valuable technique for intervention with students who exhibit inappropriate behavior and/or lack apropriate social skills. However, the literature indicates a strong need for further research on this topic (Miller, 1980; Lebsock & Salzberg, 1981; Plummer, 1982).

Psychodrama and Sociodrama

Psychodrama focuses on individuals and their emotional conflicts. It is a therapeutic technique originated and developed by J. L. Moreno who used it for treating psychiatric patients (Mathis, Fairchild & Cannon, 1980). Moreno developed psychodrama to help individuals cope with personal and interpersonal problems (Creekmore & Madan, 1981). Mathis, Fairchild, and Cannon (1980) describe psychodrama as an action technique in which an individual acts out a topic or problem situation in the presence of a critical, and supportive audience, rather than passively talking about the topic or problem.

Moreno's technique was modified to encompass problems encountered by entire groups of individuals. The modified approach, which includes dramatization of group problems and situations, was called sociodrama (Creekmore & Madan, 1981). Sociodrama focuses on the group and deals with traditional social problems. In a sociodramatic presentation the actors portray types of individuals rather than their individual self (Mathis, Fairchild, & Cannon, 1980). These authors report that sociodrama is typically used in the classroom. But psychodrama is rarely employed in a school setting because the revelation of intimate personal problems could possibly damage the student's relationships with peers.

It has been reported that sociodrama is beneficial for behavior disordered children. Support for this assertion is provided by Newcomer (1980) and Creekmore & Madan (1981).

Newcomer (1980) discussed four facets of the approach. First, if a conflict area is too sensitive or threatening for the child to deal with, sociodrama may be used to add distance to the problem by facilitating its presentation through another group member or through the child himself with a different character name. This distance allows the child to deal with his problem in terms of someone else. Second, sociodrama can be used to enhance listening disorders to establish and maintain interpersonal relationships. Sociodrama is a means used to sensitize the behavior disordered child to the feelings of others around him/her (Paiget & Inhelder, 1969). Third, through sociodrama the child may learn to take responsibility for his/her own problem resolution and personal growth. This decreases the need for external control. Emphasis is placed on the development of his/her social consciousness. Finally, sociodrama promotes spontaneity and assists the child in abandoning rigid potential maladaptive behavior patterns. Through re-experiencing events, less inhibited, more open expressions of feelings and needs may be realized.

Sociodrama may not provide the child with an explicit answer or a set pattern of behavior. Instead it may assist him/her to become more flexible and responsive to the environment.

Through exploration of various solutions to problem situations, future difficulties may be handled more appropriately (Lippitt & Clancy, 1954). In addition, it is important in educational settings, to increase social and emotional development through an enjoyable learning experience such as sociodrama. Maier (1953) affirms the relevance of sociodramatic therapy for behavior disordered children by describing its most successful uses: (1) sensitizing individuals to the feelings of others; (2) developing skills such as listening and reflecting feelings in interpersonal relationships, and (3) discovering an individual's need regarding his personal-social development.

Sociodrama appears to be a valid treatment technique for behavior disordered children. However, Maier (1953) cautions that some children may become uncomfortable by being asked to take part in a particular dramatization. Creekmore and Madan (1981) state that situations may develop which require the director to adapt the sociodrama so that the individual can save face. Also, both the actors and the audience may need assistance in interpreting and learning from the conflict resolution (Creekmore and Madan, 1981; Necco, Wilson, & Scheidemantel, 1982).

Unfortunately, a review of the available literature reveals a lack of empirical research involving the use of sociodrama as a therapeutic technique with emotionally handicapped children/youth. The concepts inherent in sociodrama, however, appear to be beneficial to exceptional children. Further research needs to be conducted to support the use of sociodrama as a viable technique (Creekmore & Madan, 1981; Necco, Wilson, & Scheidemantal, 1982).

Video Tape Activities

Recent studies have begun to show the value of video tape activities as a tool for positively influencing the social and academic growth of exceptional students (Elias, 1979). Video tape can be used to combine role play and sociodrama activities in the classroom.

One study of video tape activities reports that video taped feedback is useful in treating children with problems related to impulse control, reality testing and low self-esteem (DeFrances, Dexter, Leary, & MacMullen, 1982). The observation, clarification, and labeling of appropriate and inappropriate solutions and/or alternatives to problems has been shown to help students gain greater mastery and control over their own behavior. These authors state that video tape activities give the students a more realistic view of themselves and the outside world.

Citing effects of a group therapy project using video tape feedback Michel and Blitstein (1979) support the use of video tape activities with severely disturbed adolescents. Anecdotal evidence reported in this study demonstrated that video tape feedback facilitated the correction of the participants' distorted body images, low self esteem, lack of capacity for self-observation and poor peer relationships (Michel & Blitstein 1979).

DeFr[redacted] Dexter, Leary, and MacMullen (1982) cite studies completed by Mar[redacted]) and Noble and Grant (1977) on the effect of the video tape exp[redacted] delinquent adolescents. One study indicated that video ta[redacted]hibited a significant increase in reality based self and a mo[redacted] posture regarding their behavior. Noble and Grant (1977), sho[redacted]ant improvement in self drawings and verbal descriptions. The[redacted] showed awareness of individual differences for both current and [redacted]lf as a result of their participation in an experience using crea[redacted]ama.

Elias (1979) reported that children exposed to dramatization and video tape experiences exercise more self control over everyday and pressure situations. Results indicate that meaningful social and emotional gains are made by children participating in video tape and discussion activities.

Ferguson and Silverberg (1979) recorded the results of a video program for exceptional adolescents. They stated that "video tape activities activized class structure and the student's interest in video seemed to foster positive peer interactions. Students participating in the program showed a marked improvement in such areas as attendance and classroom behavior" (Ferguson and Silverberg, 1979, p. 511).

The review of the professional literature supports the use of video tape activities with students who exhibit inappropriate behavior and/or lack social development skills and positive peer interaction. However, the use of video tape activities in the classroom for severely emotionally disturbed students should be empirically examined in a controlled manner in both educational and therapeutic settings (DeFrances, Dexter, Leary & MacMullen, 1982; Elias, 1979; Ferguson & Silverberg, 1979; Michael & Blitstein, 1979).

Summary and Perspective

The review of the literature included a summary of three therapeutic options for use in the SED classroom. These are (1) role play, (2) psychodrama and sociodrama, and (3) video tape activities. Each of these methods have been defined and discussed. Research suggests that role play, sociodrama, and video tape activities have the potential to positively influence the social/emotional and academic growth of exceptional students.

Numerous studies suggest that the benefits of role play and sociodrama activities with exceptional students have yielded positive results. However, a lack of empirical research exists on the effects of combining role play and sociodrama activities in the classroom with the use of video or taping equipment. Studies of video tape activities report that video taped feedback has been useful in treating children with problems related to impulse control and low self-esteem. This technique may assist students in distinguishing appropriate and inappropriate solutions/alternatives to problems and real-life situations. Video tape activities complement role play and sociodrama by generating immediate feedback, positive peer interactions and a record of observable change in student appearance and behavior. It also provides a high interest activity for students. Video tape activities may be adapted to any group of students.

The SED Network has been charged with (1) the task of improving the quality of existing services and (2) diffusion of best practices and procedures for use with SED students. To meet these goals the SED Network has developed a data collection proposal focusing on the use of video tape activities for use in the therapeutic/educational environment with SED students. The goal of this study is to evaluate the efficacy of video tape activities as a therapeutic technique for use with SED students.

Research has suggested that role play and sociodrama activities may be of benefit to SED students. It appears that video tape activities will complement these two interventions and add to the value and effectiveness of achieving therapeutic goals. The proposed study will evaluate the efficacy of this technique with SED students in Pinellas County, Florida.

Based on the review of the literature on the topics of role play, psychodrama and sociodrama, and video tape activities several questions can be asked. These questions are:

1. To what extent does the use of video tape activities in the classroom for SED students improve the frequency of student attendance?

2. To what extent does the use of video tape activities in the classroom for SED students improve the participants ability to choose appropriate solutions to real-life stiuations?

3. To what extent does the use of video tape activities in the classroom for SED students assist the participants in learning appropriate social skills?

4. To what extent does the use of video tape activities in the classroom for SED students enable the participants to receive feedback on their behavior, appearance, peer interactions, and solutions to real-life situations?

5. To what extent does the use of video tape activities in the classroom for SED students decrease the frequency of the participants' verbal conflicts in the classroom setting?

6. To what extent does the use of video tape activities in the classroom for SED students decrease the frequency of the participants physical conflicts in the classroom?

7. To what extent does the use of video tape activities in the classroom for SED students decrease the frequency of the participants' placement in time out?

8. To what extent does the use of video tape activities in the classroom for SED students decrease the frequency of the participants' placement on suspension?

These questions are indicative of the anticipated results of the proposed data collection study. Each of these eight (8) questions will be reviewed following the collection and analysis of the data. The resulting conclusions will be included in the summary of this study.

IV. METHODS AND PROCEDURES

Setting

The purpose of the video tape activity data collection process is to ascertain the effects of video tape activities in the classroom for severely emotionally disturbed (SED) adolescents. The study will be conducted in two environments serving SED students. The first site is Richard L. Sanders School, a center for SED students in Pinellas County, Florida. The Adolescent Day Treatment Program (ADTP) located at Mental Health Services of Upper Pinellas County, Inc. in Pinellas County, Florida is the second setting. This site serves SED adolescents in Pinellas County and is a therapeutic/educational program jointly operated by the School Board of Pinellas County and Mental Health Services of Upper Pinellas County, Inc.

Subjects

In this study 40 subjects are required. All subjects from Richard L. Sanders (N=30) will be selected by class membership. Teachers will volunteer their time and students to participate in the study. Specifically, the three teachers and their students (who volunteer) will be assigned to one of three experimental groups. The three groups include two experimental groups and one control group. Each group will have ten subjects. A fourth group (N=10) will consist of students currently enrolled in the ADTP facility.

Student records will be examined to obtain chronological ages, achievement levels, and intelligence quotients. Students will receive an identification number and remain anonymous for purposes of the study. All subjects will be currently certified as SED according to school district and state guidelines for SED programs. All subjects (excluding the control group) will be informed about the purpose of the study and the methods which will be used in their particular classroom. Releases will be signed by both parents and students giving the permission necessary for subjects to be video taped for purposes of this study.

Instrumentation

The data collection activities in this study are described in three phases. These phases are:

1. Phase I - Pretest Data Collection
2. Phase II - Intervention
3. Phase III - Post-test Data Collection

Phase I and Phase III will occur for three (3) weeks. Phase II will take place over a six (6) week period. Data collection activities will, therefore, be completed in twelve (12) consecutive weeks.

Phase I -- Pretest Data Collection. Three weeks prior to the intervention phase of the study pretest data will be collected.

To gather information for this phase of the study five pretest data collection instruments have been developed. The Teacher Interview Form and the Teacher Class Ranking of Priorities Form are based on the Mark Twain Student Observation Scale used by the Department of Education for Exceptional Students, School Board of Pinellas County, Florida. All five instruments to be used during this study are described below.

1. Teacher Interview

   Teachers participating in this study will be asked to rate the extent to which nine (9) specific behaviors are exhibited by each of their students. The Teacher Interview Student Behavior Form will be used to collect this information (see ppendix A).

2. Teacher Class Ranking of Priorities Form

   Teachers participating in the study will be asked to rank the top five goals for their class. These five goals will be selected from behaviors adopted from the Mark Twain Student Observation Scale. Teachers will be asked to justify each of their priorities on the Classroom Goal Priorities Form (see Appendix B).

3. Priorities Reporting Form

   Observational data will be collected to record the extent to which the behaviors pinpointed as priorities by teachers following completion of the Teacher Ranking of Priorities Form actually occurred. (See Appendix B). This data will be collected in two ways. The observational data will be recorded using the Priorities Reporting Form (see Appendix C). Teachers will be asked to rate the extent to which the behaviors occur on a daily basis. External observations will be made on a random basis by an independent observer 20% of the time.

4. Student Data Form I and II

   Frequency counts will be recorded during the data collection process. The data to be collected are:

   a. attendance
   b. number of verbal conflicts
   c. number of physical conflicts
   d. restroom requests
   e. placement in time out
   f. placement on suspension

Teachers will be asked to keep a record of items B through D. Outside observers will record the data on items A, E, and F. Information will be collected by using the Student Data Form I and II (see Appendix D and E).

5. Student Questionnaire

Student data will be collected by asking each student to answer ten (10) situational questions and choose an answer. (See Appendix F).

6. Student Opinion Questionnaire

Additional student data will be generated by asking each student to complete twelve (12) questions related to their specific classroom (see Appendix G).

Phase II - Intervention. The intervention phase of the study will begin immediately following the Phase I - Pretest Data Collection. Phase II - Intervention will take place over a six week period. This phase is divided into two parts for descriptive purposes. Phase II(A) describes the intervention procedure used at Richard L. Sanders School. Phase II(B) describes the ADTP intervention procedures.

Phase II (A) - Richard L. Sanders

Three groups of subjects (N=30) are required for this study at Richard L. Sanders. Each of the three groups will include 10 subjects. These groups are (1) Experimental group I, (2) Experimental Group II, and (3) Control Group. A description of the intervention procedure to be used with each group is described below:

Experimental Group 1

This group will include 10 subjects. Students will (1) be instructed in the use of video tape equipment, (2) be instructed on how to produce a video tape of a dramatized situation, (3) develop a video tape of a situation relevant to their own lives, and (4) review and discuss the video tape produced. This video tape activity will occur one hour per week for six weeks. Each session will follow a pre-planned outline of goals, objectives, and activities. Student behavior will be observed and recorded during intervention. The following student data will be collected using the Student Data Form I and II (see Appendix D and E).

a. attendance
b. number of conflicts (verbal)
c. number of conflicts (physical)
d. restroom requests
e. placement in time out
f. placement on suspension

Experimental Group II

This group will include 10 subjects. Students will (1) view video tapes of dramatized situations relevant to their lives, and (2) discuss the video tapes reviewed. These students will not be instructed (1) in the use of video tape equipment, (2) on how to produce a video tape of a dramatized situation or (3) on how to develop a video tape situation. This video tape activity will occur one hour per week for six weeks. Each session will follow a pre-planned outline which introduces the video tape and offers sample discussion questions. Student behavior will be observed and recorded during intervention. The following student data will be collected by using the Student Data Form I and II (see Appendix D and E).

a. attendance
b. number of conflicts (verbal)
c. number of conflicts (physical)
d. restroom requests
e. placement in time out
f. placement on suspension

Control Group

This group will include 10 subjects. Students will not receive intervention related to this study. Student behavior will be observed and recorded during the six week intervention phase. The following student data will be collected by using the Student Data Form I and II (see Appendix D and E).

a. attendance
b. number of conflicts (verbal)
c. number of conflicts (physical)
d. placement in time out
e. placement on suspension

Phase II(B) - ADTP

One group of subjects (N=10) is required for this study at the ADTP. The subjects in this group have previously been exposed to video tape activities as a component of their educational and therapeutic program. Information collected regarding the subjects in this group will be used as comparison data. The following information will be collected by using the Student Data Form I and II (see Appendix D and E).

a. attendance
b. number of conflicts (verbal)
c. number of conflicts (physical)
d. placement in time out
e. placement on suspension

Phase III - Post-test Data Collection. Three weeks immediately following the intervention phase, post-test data will be collected. To gather information for this phase of the study five instruments will be used. The same six data collection instruments described in the pre-test data collection, Phase I, will be used as post-test instruments. The six instruments are listed below. Descriptions of revisions for post-test purposes are also provided. A seventh instrument will also be used to assess teacher opinion of the video tape activity.

1. Teacher Interview

   Teachers participating in this study will rate the extent to which nine (9) specific behaviors are exhibited by each of their students. The Teacher Interview on Student Behavior Form will again be used to collect this information (see Appendix A).

2. Teacher Ranking of Class Priorities Form

   Teachers participating in the study will rank the top five goals for their class. These five goals will be selected from behaviors adopted from the Mark Twain Student Observation Scale. Teachers will then justify each of their priorities on the Classroom Goal Priorities Form for post-test purposes (see Appendix B).

3. Priorities Reporting Form

   For post-test data collection purposes this information will be recorded using the Priorities Ranking Form (see Appendix C). Observers will record the frequency of the behaviors pinpointed as priorities by teachers during pre-test data collection using the Teacher Ranking of Priorities Form (see Appeneix B).

4. Student Data Form I and II

   For purposes of post-test data collection the frequency of the following items will be recorded. Items to be counted are:

   a. attendance
   b. number of verbal conflicts
   c. number of physical conflicts
   d. restroom requests
   e. placement in time out
   f. placement on suspension

   Teachers will be asked to keep a record of items B through D. Outside observers will record the data on items A, E, and F. Information will be collected by using the Student Data Form I and II (see Appendix D and E).

5. Student Questionnaire

Student data will be collected by asking each student to answer ten (10) situational questions and choose an answer (see Appendix F).

6. Student Opinion Questionnaire

Additional student data will be generated by asking each student to complete twelve (12) questions related to their specific classroom (see Appendix G).

7. Teacher Opinion Questionnaire

For post-data collection information only, teachers participating in the study will be asked to complete a fourteen (14) question instrument designed to assess teacher opinion related to video tape acivities (see Appendix H).

Data Analysis

The data obtained from the six data collection procedures will be analyzed by using two techniques. These techniques (1) graphic visual representation and (2) inferential statistical procedures will provide a thorough examination of all data obtained.

Graphic Visual Representation

Data will be summarized by transforming the numeral frequencies from each observation session into a single data point. For each subject six data points will be generated; one for each observation period.

To detect relations in the data or between the data and the independent variables of the four experimental groups, information will be displayed in the form of tables and graphs. Tables will be generated for each experimental group. Relationships will be manifested by the spatial relationships of components of the graphic display. The components will include the mean frequencies for all observed student behaviors in the pre-data collection, intervention, and post-data collection phases. An equal interval chart of the mean scores of frequencies of the operationally defined behaviors will be used.

Statistical Procedures

The data will be analyzed by employing (1) t-test procedures and (2) analysis of variance procedures. For each data collection activity (e.g., teacher interview, classroom priorities, observational data, student data, student situational questionnaire) different procedures will be used. For each of the five activities a t-test of significant differences will be used to compare pre-and post-test scores. A 2 x 4 factoral analysis of variance design will be used to compare differences among the four experimental conditions. The analysis of variance will be completed for all three experimental phases: pre-, post-, and intervention.

The means, standard deviations, and analysis of variance for the data obtained will be presented in summary tables. In addition Tukey's HSD procedure will be used posteriori as a follow-up examination of the results.

Summary of Methods, Procedures, and Data Analysis

The purpose of the video tape activity is to ascertain the effects of video tape activities in the classroom for severely emotionally disturbed (SED) adolescents. Two environments will be used in this study. They are (1) a center for SED students and (2) an Adolescent Day Treatment Program, both located in Pinellas County.

Data collection activities within this study have been described in three phases. They are (1) Phase I - Pre-test Data Collection (3 weeks), (2) Phase II - Intervention (6 weeks), and (3) Phase III - Post-test Data Collection (3 weeks). The proposed study will, therefore, take place over a twelve week period of time.

Six specific data collection instruments will be used to collect pre- and post-test information. In addition, a seventh instrument will be used during Phase III to assess Teacher Opinion related to the use of video tape activities. Student observations will be collected daily throughout the twelve week data collection process.

Data will be analyzed by using two techniques. They are (1) graphic visual representation and (2) inferential statistical procedures. These procedures will provide a thorough examination of all data obtained.

Materials (Equipment)

The following equipment is necessary for production of video tapes:

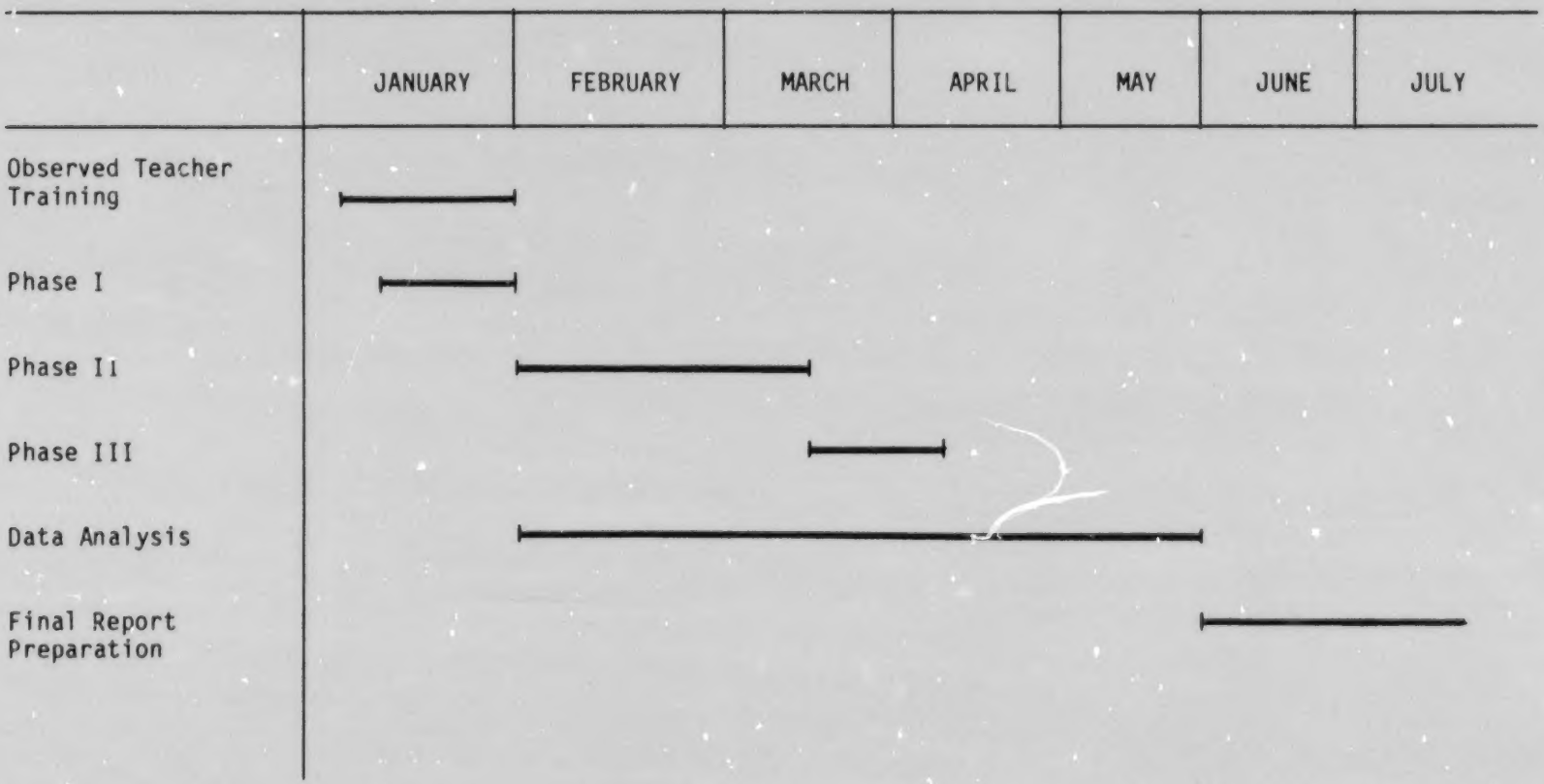
1. 3 RF cables
2. 1 splicer (to connect two television monitors to deck)
3. 2 color monitors (19" or 21")
4. 1 3/4" video tape deck
5. 1 1/2" video tape deck
6. 1 color camera
7. 1 extension cord
8. Props for settings (as needed)

APPENDICES

TABLE I

SED NETWORK VIDEO TAPE ACTIVITY

TIMELINE OF EVENTS



APPENDIX A

TEACHER INTERVIEW -- STUDENT BEHAVIOR FORM

Teacher Name_____ Student Name_____ Date_____

Based on your observations of the student, rate the extent to which his/her performance in the areas listed below has been exhibited in the past two (2) months. Check the appropriate response.

	(1) Almost Never (5%)	(2) Very In-frequently (20%)	(3) In-frequently (35%)	(4) Moder-ately (50%)	(5) Frequently (65%)	(6) Very Frequently (80%)	(7) Almost Always (95%)
1. Classroom Conformity Student follows established class-room routines	(1)	(2)	(3)	(4)	(5)	(6)	(7)
2. Self-Worth Student accepts praise and/or encouragement	(1)	(2)	(3)	(4)	(5)	(6)	(7)
3. Self-Responsibility Student accepts consequences of his/her own behavior	(1)	(2)	(3)	(4)	(5)	(6)	(7)
4. Emotional Control Student reacts appropriately to constructive criticism	(1)	(2)	(3)	(4)	(5)	(6)	(7)
5. Problem Solving Student chooses appropriate behavior alternatives	(1)	(2)	(3)	(4)	(5)	(6)	(7)

	(1) Almost Never (5%)	(2) Very In-frequently (20%)	(3) In-frequently (35%)	(4) Moder-ately (50%)	(5) Frequently (65%)	(6) Very Frequently (80%)	(7) Almost Always (95%)
7. Acceptance of Authority Student complies with school rules and regulations	(1)	(2)	(3)	(4)	(5)	(6)	(7)
7. Respect for Others Student shows regard for the needs and feelings of others	(1)	(2)	(3)	(4)	(5)	(6)	(7)
8. Social Skills Student works cooperatively with peers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
9. Task Orientation Student works with the teacher with supervision	(1)	(2)	(3)	(4)	(5)	(6)	(7)

Thank you for completing this scale.

Adopted from the Mark Twain Student Observation Scale

APPENDIX B

Teacher Class Ranking of Priorities Form

Teacher Name _____ Date _____

Directions

Rank the following nine (9) goals listed below relative to their importance to your class. Please select five (5) of the goals listed below as those you feel are most important to your class. Then, justify (give your rationale) your reason for ranking each one. (Priority #1 should indicate the most important goal out of the five goals chosen. Priority #5 should indicate the least important goal out of the five goals chosen.)

_____ a) Student follows established classroom routines
_____ b) Student accepts praise and/or encouragement
_____ c) Student accepts consequences of his/her behavior
_____ d) Student reacts appropriately to constructive criticism
_____ e) Student chooses appropriate behavior alternatives
_____ f) Student complies with school rules and regulations
_____ g) Student shows regard for the needs and feelings of others
_____ h) Student works cooperatively with peers
_____ i) Student works with the teacher with supervision

PRIORITY #1: _____

_____

JUSTIFICATION: _____

_____

_____

PRIORITY #2: _____

_____

_____

APPENDIX B - continued

PRIORITY #3: _____

_____

JUSTIFICATION: _____

_____

_____

PRIORITY #4: _____

_____

JUSTIFICATION: _____

_____

_____

PRIORITY #5: _____

_____

JUSTIFICATION: _____

_____

_____

Thank you for completing this form.

Adopted from the Mark Twain Student Observation Scale

APPENDIX C

PRIORITIES REPORTING FORM

Teacher Name_____ Date _____

Time Observed

Directions:

Please complete this form each day immediately following the time indicated above. Indicate the proportion of your class that demonstrated the behaviors as listed.

I. Classroom Conformity

Students follow established classroom routine ____ (# exhibited behavior) / (# in attendance)

II. Self Worth

Students accept praise and/or encouragement ____ (# exhibited behavior) / (# in attendance)

III. Self-Responsibility

Students accept the consequences of their own behaviors ____ (# exhibited behavior) / (# in attendance)

IV. Emotional Control

Students react appropriately to constructive criticism ____ (# exhibited behavior) / (# in attendance)

V. Problem Solving

Students choose appropriate behavior alternatives ____ (# exhibited behavior) / (# in attendance)

VI. Acceptance of Authority

Students comply with school rules and regulations ____ (# exhitited behavior) / (# in attendance)

APPENDIX C - continued

VII. Respect for Others

Students show regard for the need and feelings of others ____ (# exhibited behavior) / (# in attendance)

VIII. Social Skills

Students work cooperatively with their peers ____ (# exhibited behavior) / (# in attendance)

IX. Task Orientation

Students work with teacher supervision ____ (# exhibited behavior) / (# in attendance)

Thank you for completing this form

Adopted from the Mark Twain Student Observation Scale

APPENDIX D

STUDENT DATA FORM I

WEEK OF: _____ TEACHER'S NAME _____

NAME	VERBAL CONFLICT					PHYSICAL CONFLICT					RESTROOM REQUEST				
	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F

APPENDIX E

STUDENT DATA FORM II

WEEK OF: _____ TEACHER'S NAME _____

NAME	ATTENDANCE					TIME-OUT					SUSPENSION				
	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F

APPENDIX F

STUDENT QUESTIONNAIRE

Directions:

For each of the following items, check what you would do if the action happened to you.

1. You were asked to stop talking out because you didn't raise your hand. What would you do?

   ____ a. Stop talking and start working,
   ____ b. Stop talking and refuse to work,
   ____ c. Start arguing with your teacher and talking louder,
   ____ d. Ask permission to go to the restroom.

2. Your teacher asks you to give a spelling test to a classmate. What would you do?

   ____ a. Tell the teacher: "Give the test yourself,"
   ____ b. Ask if another student can do it,
   ____ c. Give the test to your classmate,
   ____ d. Continue doing your math assignment.

3. Your teacher asks you to do an assignment with him/her. What would you do?

   ____ a. Do you assignment,
   ____ b. Ask to go to the counselor for help with the assignment,
   ____ c. Sit with the teacher but not do the work,
   ____ d. Tell the teacher you did the assignment already and refuse to do it again.

4. You get a high grade on a test and your teacher tells the whole class about it. What would you do?

   ____ a. Ignore the compliment and stare out the window,
   ____ b. Thank the teacher and continue working,
   ____ c. Ask to go to the restroom,
   ____ d. Ask to talk to the school counselor because you're embarrassed.

5. You are told to go to timeout because you swore at the teacher. What would you do?

   ____ a. Refuse to go to timeout, using more bad language,
   ____ b. Go to timeout because I did something wrong,
   ____ c. Ignore the teacher and continue working,
   ____ d. Ask the teacher if you can do a math worksheet.

APPENDIX F - continued

6. Your classmates start throwing paper and pencils when your teacher is out of the room. What would you do?

____ a. Throw stuff with them, even after the teacher returns,
____ b. Leave and find the teacher or another adult,
____ c. Ignore them and continue working,
____ d. Laugh and tell your friends to continue.

7. Your teacher looks at a sloppy assignment and tells you that you need to improve your handwriting. What would you do?

____ a. Practice your handwriting to improve it,
____ b. Get angry and throw the assignment in the trash,
____ c. Ask for help after school,
____ d. Ignore her and do your math.

8. A classmate is having a bad day and wants to talk to you about it. What would you do?

____ a. Walk away,
____ b. Tell him to talk to the counselor or teacher about it,
____ c. Laugh loudly and tell others about it,
____ d. Ask what you can do to help.

9. You are caught running in the halls and asked to stop. What would you do?

____ a. Keep running and tell the teacher not to bother you,
____ b. Tell the teacher you are late for counseling,
____ c. Stop running,
____ d. Stop running but walk very fast.

10. Your teacher compliments you on what you are wearing. What would you do?

____ a. Say "thank you" and continue working,
____ b. Tell the teacher: "Mind your own business,"
____ c. Ask to go to the restroom,
____ d. Ignore the compliment.

Thank you for completing this questionnaire.

APPENDIX G

STUDENT OPINION QUESTIONNAIRE

Student Name _____ Date _____

Directions:

Please circle the right answer.

1. I am happy to be in this class.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

2. I come to school because I am in this class.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

3. This class helps me learn to make good decisions.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

4. This class helps me learn how to cooperate with others.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

5. This class helps me to learn about myself.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

6. This class helps me learn not to fight.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

7. This class helps me learn how to control myself.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

APPENDIX G - continued

8. This class helps me to learn.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

9. This class helps me to like being in school.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

10. My favorite thing about this class is _____

_____

11. My least favorite thing about this class is _____

_____

12. If I skipped a class, this class would be the one.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

Thank you.

APPENDIX H

TEACHER OPINION QUESTIONNAIRE

Teacher's Name_____ Date _____

Please answer the following questions.

1. What impact do you think video tape activities have when used with SED students?

_____

_____

_____

2. Do you think video tape activities are valuable when used with SED students? Why or why not?

_____

_____

_____

3. Do you think the use of video tape activities with SED students improves their rate of attendance? Why or why not?

_____

_____

_____

4. Do you think the use of video tape activities has improved your students' ability to choose appropriate solutions to real-life situations? Why or why not?

_____

_____

_____

5. Do you think the use of video tape activities has helped your students learn appropriate social skills? Why or why not?

_____

_____

_____

APPENDIX H - continued

6. Do you think the use of video tape activities has enabled your students to receive feedback on their behavior, appearance, peer interactions, and/or solutions to real-life situations? Why or why not?

_____

_____

_____

7. Do you think the use of video tape activities has helped to decrease the number of verbal conflicts in your classroom? Why or why not?

_____

_____

_____

8. Do you think the use of video tape activities has helped to decrease the number of physical conflicts in your classroom? Why or why not?

_____

_____

_____

9. Do you think the use of video tape activities has helped to decrease the use of time-out with your students? Why or why not?

_____

_____

_____

10. Do you think the use of video tape activities has decreased the use of suspension with your students? Why or why not?

_____

_____

_____

11. What did you enjoy the most about using video?

_____

_____

_____

APPENDIX H - continued

12. What did you enjoy the least about using video?

_____

_____

_____

13. What additional assistance could you have used during the video tape activity?

_____

_____

_____

14. Comments: _____

_____

_____

_____

JUVENILE WELFARE BOARD FUNDING APPLICATION

PART I

NARRATIVE

PROGRAM TITLE: Community-Based Class Program *

SPONSOR AGENCY: Mental Health Services of South Pinellas County, Inc.
Child Guidance Center
3820 Central Avenue
St. Petersburg, FL 33711
Telephone: 327-7656

DATE AGENCY INCORPORATED: July 1, 1981 (MHSSP)

PROJECT DIRECTOR: John White - Child Guidance Center
Susan Avery - School Board of Pinellas County
Mental Health Liaison

TOTAL PROJECT COST: $54,607.43 TOTAL REQUESTED: $19,306.00

BEGINNING DATE: January 23, 1984 ENDING DATE:

* This proposal was developed through a cooperative multiagency effort by Mental Health Services of South Pinellas, Inc. - Child Guidance Center, the School Board of Pinellas County and the SED Network.

I. Project Summary

The intent of this program is to provide a unique educational and therapeutic model to serve severely emotionally disturbed adolescent whose psyciatric diagnosis come under the broad heading of Conduct Disorder with the following DSM III descriptions:

1. undersocialized, aggressive (312.00)
2. undersocialized nonaggressive (312.10)
3. socialized, aggressive (312.23)
4. socialized nonaggressive (312.21)

These students have been unsuccessful in the most restrictive educational program the School Board of Pinellas County currently provides, the SED Center. The Community Based Class Program will be piloted as an extension class of Richard L. Sanders School (SED Center) which serves only severely emotionally disturbed students. The major objective of this program is to separate the unsuccessful child from SED Center peer stimulation and place the student in an intensive educational and therapeutic environment.

II. Needs Assessment

There exists a population of severely emotionally disturbed students who because of specific common characteristics have experienced social and educational failure in both school and the community. These characteristics include but are not limited to:

1. long history of self-destructive, volatile, aggressive behaviors;
2. nonresponsiveness to academic or traditional therapeutic programs;
3. experience of failure in the SED Center's classroom;
4. have been fostered in a dysfunctonal family unit;
5. involvement with the court system;
6. disruption of the school environment;
7. success with one-to-one instruction;
8. nonresponsiveness to treatment in available residential facilities;
9. possible threatening behavior to students and staff;
10. displays uncooperative behaviors;
11. inability to adhere to traditional behavior management techniques and respond favorably to school authorities;
12. inappropriate social interaction skills.

Students to be considered for placement in this program generally have had extensive involvement with the Juvenile Court System as well as with Health and Rehabilitative Services. However, the success of the Community Based Class Pilot Program depends largely upon the cooperation of those agencies in the community who provide services to these students.

The intent of the program is to develop a model that will combine the efforts of both the Pinellas County Schools and Mental Health Services of South Pinellas to effectively address the needs of this population. The teacher and the Mental Health Therapist, will coordinate multiagency services such as:

1. Richard L. Sanders Schools, Pinellas County School System
2. Mental Health Services of South Pinellas, Child Guidance Center
3. Health and Rehabilitative Services
4. Sixth Judicial Circuit Court

5. Juvenile Detention Center
6. SED Network

This is an effort to maximize the positive effects on the student in the Community-Based classroom.

At the present time, there are no programs serving this population in the Pinellas/Pasco region. However, similar programs in Rockville, Maryland and Minneapolis, Minnesota have served as program models from which the Community Based Class Program was designed.

III. Measurable Objectives

1. To serve eight youth during the funding period (through 7-31-84).
2. To serve at least 10 parents or surrogate parents during the funding period.
3. To provide 2200 staff hours of direct service during the funding period.
4. To obtain an 80% consumer satisfaction rating when surveying all client families (conducted according to JWB specifications).
5. The program will provide an average of four (4) hours of services per day to each youth. Youth will participate at least 70% of the time. (A report of the number of class hours provided each quarter and the average daily attendance during the quarter will be developed.)
6. The Community Based Program will provide an extensive therapeutic component with emphasis on family involvement as follows:

   a. Individual therapy to the youth client in at least two (2) sessions per week.
   b. Group therapy to the youth client in one (1) session per week for the first three months of treatment and at least two (2) sessions after the first three months of treatment.
   c. An average minimum of one (1) family therapy session, group therapy session or educational activity for parents and other family members as appropriate per week. The program will conduct at least one (1) home visit with the family unless special conditions preclude this.

7. The program will conduct at least two (2) coordinating meetings involving the following community resources:

   a. Health and Rehabilitation Services
   b. Sixth (6th) Judicial Circuit Court
   c. Community Mental Health Services
   d. SED Network
   e. Other human services provider agencies or community groups.
   f. Meetings involving community resources will be either on an individual or group basis.

8. Participating youth will achieve academic improvement which is at least at a rate equivalent to the academic achievement of those youth participating at the Sanders SED Center as measured by standardized tests.

9. To obtain 80% satisfaction rating in surveying other agencies which have provided support services to children or the families of children participating in the program or the program itself.

10. Fifty percent (50%) of participating students will be readmitted to the Sanders SED Center or an appropriate community program which is less restrictive (i.e., job placements, day treatment, outpatient services) as determined by the Department Education for Exceptional Students, DEES, Staffing Team).

Part I

IV. Methodology/Program Structure

1. Geographical Area Served:

The Community Based Class Program will serve only those students who are eligible to be enrolled at Richard L. Sanders School. Specifically, the program will draw from the sourthern georgraphic area of Pinellas County that extends south of Ulmerton Road.

2. Public Transportation:

It is anticipated that transportation will be provided by the Pinellas Suncoast Transit Authority. The School Board of Pinellas County will provide students with free public bus cards.

3. Certifications:

The Community Based Class Program will meet all state and federal requirements for certification. Professional certification or licensing of staff will be required. The teacher will be a certified teacher of the emotionally handicapped in the State of Florida.

4. Handicap Facilities:

The proposed program site, Enoch Davis Center, complies with Section 504 of the Rehabilitation Act of 1973.

5. Gaps/Alternative Services:

Students meeting the Program criteria would receive both intensive therapeutic services as well as an educational program offered on a one-to-one basis. The advantages of the Community Bsaed Class Program are that it:

a. provides a neutral, nonthreatening environment for students;
b. relieves the SED Center of disruptions to the other students' learning process;
c. removes peer pressure;
d. fosters parental involvement and student's independence;
e. offers an educational alternative to suspension/expulsion;
f. provides the SED Center proram an alternative which was previously unavailable;
g. offers educational and therapeutic services on an individual basis;
h. provides the opportunity to gear services more to the individual student.

The Community Based Class Program has been designed to offer the non-functional Severely Emotionally Disturbed student an alternative to residential treatment. A student not receiving services provided by the Community Bsed Class Program may be destined to decompensate, and thus, require more restrictive residential care. Often this care must be provided outside of the local community.

Part I

Without the Community Based Class Program as part of the local continuum of care, more expensive residential treatment programs may need to be provided.

6. Eligibility:

Criteria for placement in the Community Based Class Program include:

I. Adolescents who are 12-19 years of age.

II. Students who have been staffed and certified for placement at the Richard L. Sanders School.

III. Dysfunction documentation of the SED Center class/school. The documentation is specific to but not cumulative of or limited to:

A. Consistent aggressive non-physical behaviors that have historically interferred with a safe, therapeutic classroom environment:

1. verbal threats, intimidation;
2. excessive disruptions to class/school;
3. inability to form appropriate peer relationships.

B. Consistent and/or severe physically aggressive behaviors:

1. destructive to self;
2. destructive to others;
3. destructive to property.

C. Suspension from school:

1. after a total of 5 days of suspension the Pinellas County Discipline Review Board would meet to consider Community Based Class Program for Sander's student;
2. after a single specific physically aggressive behavior, a suspension would occur that could result in the principal requesting the Discipline Review Board to consider placement in the Community Based Class Program.

D. Court involvement or past residential placement.

1. Previous court involvement:

a. specific charges of assault, battery and/or vandalism;
b. unresponsive to previous judicial interventions, i.e., work program and/or court ordered mental health out-patient counseling.

Part I

2. Previous residential placement:

   a. Okeechobee Training School
   b. Eckerd Camps
   c. State Hospital
   d. Local residential
   e. Other residential

7. Service Availability:

The educational component of the Community Based Class Program when in operation will follow the approved Pinellas County School calendar. The class will be in session during summer vacation following the approved summer school calendar. Students will participate in the educational program five (5) days a week for two-and-a-half (2-1/2) hours each day. The therapeutic component will parallel the educational schedule with service provided during the ten (10) weeks of summer and during regular scheduled teacher vacation time. Students will participate in the therapeutic component five (5) days a week. However, Mental Health Services will be established during evenings and after school hours to accommodate the specific needs of the clients and/or families. Initially the program will be located at Enoch D. Davis Center, 1111 18th Avenue South, St. Petersburg, Florida.

8. Phase-In Schedule:

The School Board of Pinellas County has already funded the Community Based Classroom teacher and aide. The program is scheduled to be operational at Enoch D. Davis Center by December. The Mental Health Professional will join the program contingent upon funding of the position. Full staff should be on site by December 1, 1983.

9. Intake Procedure:

Students that meet the criteria for the program will be referred by either:

a. Staff members of Richard L. Sanders School; or
b. A staffing committee chaired by the Director of Student Discipline.

Please refer to the (1) Referral Form (Addendum I), and (2) Referral Procedure (Addendum II).

Upon completion of the referral form, a review committee will meet to determine if placement in the Community Based Class Program is appropriate. This committee will consist of the following members:

* a. Behavior Specialist at Richard L. Sanders School;
* b. Social Worker or Psychologist at Richard L. Sanders School;
* c. Referring teacher or teacher representative;

Part I

* d. Community Based Class Program teacher;
* e. Community Based Class Program Mental Health Therapist;
* f. Designated administrative representative from Richard L. Sanders School;
* g. SED program supervisor or designee;
* h. Area Staffing Supervisor or Staffing Specialist;
  i. Guidance Counselor at Richard L. Sanders School;
  j. Parent;
  k. Community agency representative, HRS Community Control (mandatory communication, not attendance);
  l. Director of Student Discipline;

(Initially SED Network staff may participate on the committee.)

* a to h must be present for a review of potential Community Based Class Program placement.

10. Client Records:

All educational records will be housed at Richard L. Sanders School with appropriate copies at the Department of Education for Exceptional Students (DEES). The Individual Therapeutic and Educational Program (ITEP) will be utilized in the Community Based Class Program. MHSSP may choose to open and maintain an additional patient chart for each child and his family participating in the Program. As with other clinical charts, the records will contain clinical evaluations, progress notes, reports, correspondence and administrative documentation. Clinical records will be kept in locked file cabinets at the Central Avenue Office of Mental Health Services of South Pinellas.

11. Parent Involvement:

Initially parents/guardians will be involved through the referral and review process with Richard L. Sanders School. Involvement with the family will be an integral part of the Community Based Class Program. The Mental Health Professional will assume the responsibility of family-school liaison. Family involvement will be through home visits. Family therapy and the development of parenting skills wil be provided on an as needed basis.

12. Volunteers:

Due to the severe behavior of the students placed in the Community Based Class Program, volunteers will not be involved. However, volunteers through the School Board of Pinellas County Volunteer Program may be involved in advocacy activities for the SED population. MHSSP does not choose to involve volunteers in this program.

Part I

13. Outreach:

The School Board of Pinellas County employs school social workers that are assigned to specific schools. Richard L. Sanders School presently has assigned one full-time and one part-time social worker. It is the responsibility of the school social worker to serve in an outreach capacity. Because the Community Based Class Program will be an extension class of Richard L. Sanders, the school social workers assigned to Sanders will be responsible for disseminating program information. Outreach activities for students assigned to the Community Based Class Program will also be provided by the Mental Health Professional in conjunction with Sanders School staff.

14. Coordination of Services:

The Community Based Class Program is a cooperative effort of multiple agency service providers. The School Board of Pinellas County, Mental Health Services of South Pinellas, Health and Rehabilitative Services, and the 6th Judicial Circuit Court will implement coordinated services with the assistance of SED Network staff.

15. After-care:

After-care functions will be performed by the school social worker at the time the student re-enters school at Richard L. Sanders. Based on recommendations from the Mental Health Professional, the use of Mental Health out-patient services for specific students will be monitored by either the school social worker or Community Based Class Program Mental Health Professional depending upon placement of student at either Richard L. Sanders or the Community Based Class.

16. Typical Client Process:

After a student has been referred (see Intake [i]) and certified for placement in the Community Based Class Program, the student will be reassigned to the Community Based Class. A typical student day is two-and-a-half (2-1/2) hours in length. While in class the student will receive one-to-one academic instruction in specific required academic subjects. If possible, the Community Based Class Program teacher will follow the academic curriculum developed by the referring teacher at Richard L. Sanders. However, program emphasis will be on the remediation of the specific observable behaviors that were the cause of placement in the Community Based Class Program.

Based upon the dysfunctional behaviors identified through the referral process, the teacher and Mental Health Professional will concentrate on those behaviors that hve been consistent with the student's inability to function appropriately in the SED Center. A therapeutic milieu will be provided through the use of affective curriculum as well as daily and individual and/or group therapy provided by the Mental Health Professional and the Community Based staff. In addition to these services, families of students placed in the Community Based Class Program will work closely with the Community Based Staff.

Part I

By design the close proximity of the facility to student's homes provide the option for the student to leave the class. The student is expected to participate in the Community Based Class Program by choice. When they are not able to function in the classroom, their option is self-exclusion. The mental health therapist would then be available for immediate follow-up to explore the student's needs in the hope of their return to tne class the next day. If a student should become physically out of control, staff would call upon all available resources including other program staff, building security personnel, and community police. It is the intent of the program to remediate specific behaviors so that the student may be successfully integrated back into Richard L. Sanders school. The following is the criteria and procedure for re-entry into Richard L. Sanders School.

Criteria for Re-entry into Richard L. Sanders School

A. A student must be enrolled in the Community Based school a minimum of 9 weeks with a 90% attendance rate before being considered for placement back into Richard L. Sanders School.

B. Target goals and objectives stated in the Individual Therapeutic and Educational Program (ITEP) must be achieved with 90% accuracy.

C. An observation by the R. L. Sanders Behavior Specialist will be required before re-entry.

D. Re-entry into Richard L. Sanders School will be gradual and systematic. A trial period will consist of:

1. A two week period during which the student spends a reduced day at Richard L. Sanders followed by processing sessions with the mental health professional on an as-needed basis;

2. After successful completion of the two (2) week period, the student will be placed at Richard L. Sanders for a three (3) week full-time transitional period;

3. Upon successful completion of the three (3) week full time transitional period, the student will be returned to an appropriate classroom placement at Richard L. Sanders School;

4. The ITEP will be revised by both Community Based Program staff and Sanders staff. During this time, recommendations will be made that may include:

   a. mental health out-patient service;
   b. individual academic tutoring;
   c. others.

5. In the event that the student is unsuccessful during the three (3) week full-time transitional placement at Richard L. Sanders, two (2) options may be considered:

   a. shorten the day program at Richard L. Sanders;
   b. return to the Community Based Class Program.

Part I

Finally, because schedule flexibility is an integral part of the Community Based Class Program, the following is a list of issues concerning scheduling:

A. Students placed in the Community Based Class Program will qualify for a reduced day schedule;

B. Initially the student will receive a maximum of twelve-and-a-half (12-1/2) hours per week of classroom instruction;

C. No more than two (2) students at one time will be scheduled in the classroom;

D. The maximum class load will be eight (8) students;

E. Contact hours will increase as the student approaches the transitional phase of the Community Based Class Program;

F. A current classroom schedule will be submitted to the principal at Richard L. Sanders;

G. The Community Based classroom teacher and mental health professional will receive a half (1/2) hour planning time and a half (1/2) hour duty free lunch as stated in the School Board of Pinellas County Teacher's Contract.

17. Staff Turnovers

None.

18. Promotions

None

19. Organization Chart

See attached.

20. Research Activities

This is not a research project.

21. Future Funding

Funding requests for this Program will be on-going;. As the Program is replicated, support will be requested to fund additional Mental Health Professionals. The other major source of funds for this program come from the School Board of Pinellas County. Exploration of additional funding from Health and Rehabilitatiave Services may be considered as expansion of the program is warranted.

Part I
Addendum I

REFERRAL TO CENTER REVIEW COMMITTEE

STUDENT INFORMATION

DATE _____

STUDENT NAME _____ D/B _____

STUDENT NUMBER _____ REFERRING PERSON _____

I. Reason for Referral

A. Classroom Conformity

_____ pokes, torments, or teases classmates
_____ interfers with the work of peers
_____ swears, obscene language
_____ intimidates other students or staff
_____ shows disrespect to teacher
_____ acts of deviant
_____ breaks class rules

B. Self-Management

_____ copes inappropriately with frustration
_____ expresses feelings appropriately
_____ reacts violently to constructive criticism
_____ abuses peers verbally
_____ abuses peers physically
_____ encourages abuse of peers
_____ abuses staff verbally
_____ abuses staff physically
_____ abuses school property
_____ demonstrates successful interaction on a one-to-one ratio with peer
_____ demonstrates successful interaction on a one-to-one ratio with adult
_____ responds appropriately to adult initiated contact

C. Social Skills

_____ demonstrates the inability to form successful peer relationships
_____ seeks excessive peer attention
_____ has been unsuccessful in traditional mental health service programs
_____ attempts to manipulate staff/peers
_____ has previous court system involvement
_____ has had previous placement in residential/training school facilities
_____ can work productively when removed from peer antagonism
_____ benefits from a reduced hour day program
_____ has been suspended from school
_____ has been excluded from school

Part I

II. Alternative Center Interventions Attempted

_____ change of academic curricula
_____ change of vocational program
_____ transfer to other teacher
_____ additional individual counseling
_____ crisis intervention techniques attempted (list)

_____

_____

_____

_____ social worker involved with parent/guardian
List number of and date of home visits: _____

_____

_____

_____ modification of behavior management program
_____ involvement of specific community agencies (list)

_____

_____

_____

_____ teacher contact with parents/guardian
Type of contact: _____ date _____
_____ date _____
_____ date _____
_____ date _____

III. Results of These Interventions

_____

_____

_____

_____

IV. Documentaion of either physical or non-physical aggressions on self, staff, students or property (Forms Attached).

V. Recommendation of Referring Person

_____

_____

_____

_____

VI. Recommendations of Review Committee

_____

_____

_____

_____

_____

Part I

Date _____

Parent's or Guardian's Signature _____

Address _____

Case Manager - Signature _____
(Name) (Title)

_____
(Name) (Title)

_____
(Name) (Title)

_____
(Name) (Title)

_____
(Name) (Title)

_____
(Name) (Title)

The recommendation has been made that your child _____ be transferred to a Community Based Class Program. Your child's educational status will not be changed without your knowledge.

VII. The IEP has been reviewed and changed as necessary. _____
(Date)

Parent/Guardian has signed new IEP. _____
(Date)

Part I
Addendum II

REFERRAL PROCESS

Procedures and Guidelines

A. Referrals can be made by:

1. Richard L. Sanders Center teachers;
2. Richard L. Sanders Center support staff;
3. Staffing Committee chaired by the Director of Student Discipline.

B. Only those students who meet the specific established criteria should be considered.

C. Any student who has been determined to be dysfunctional in the Center (based on the criteria) and has either court involvement or residential placement will be considered as a high risk candidate.

D. High Risk candidates will take priority over all other referrals.

E. A complete referral form must be submitted to the Review Committee.

F. The Review Committee will meet within 48 hours to determine if placement into the Community Based Class is appropriate.

G. A recommendation will be made.

H. Parent (if not present at the Review Committee) will be notified or change in class.

I. Appropriate changes in the IEP will be made.

Part I

IV. Methodology/Program Structure (cont'd)

Part B

Complete your response to the following items in the space provided below and incorporate this sheet as a part of your application.

1. Number of youth (primary clients under 18) you expect to serve directly during upcoming program year. _____

2. Number of adults (primary clients over 17) you expect to serve directly during upcoming program year. _____

3. Number of youth (primary clients under 18) served directly during the most recently completed program year. _____

4. Number of adults (primary clients over 17) you served directly during the most recently completed program year. _____

5. Program capacity - How many clients can you meaningfully serve at one time? _____

6. Average length of stay - This is the approximate length of time service is provided, counted in days, weeks, or months from the time a client is admitted to the program (after intake) until service is completed (excluding any "after care" service). _____

7. Frequency/Intensity - This is the average number of times that a client is seen in a face-to-face contact by a staff person toward the accomplishment of a service/case plan. (Residential, daily, weekly, etc.) _____

For Residential Programs: This refers to the maximum number of clients who can be served in the program on any given day.

For Non-Residential Programs: This refers to the maximum number of clients the program can serve in a 30-day period.

If your program is both Residential and Non-Residential, please provide capacities for both.

Part I

IV. Methodology/Program Structure (cont'd)

Part B

8. Duration of contact - This is the approximate length of time of a typical contact. For example: 24 hours (residential), 4 hours, 1 hour, etc. _____

9. What is the average staff-client ratio? _____

10. What percent of your staff received cost-of-living increases during the past year? What was the average increase? _____

11. What percent of your staff received other salary increases during the past year? What was the average increase? _____

12. What percent of your professional staff are ethnic minority? _____

13. What percent of other staff are ethnic minority? _____

14. How many hours of training was provided staff within the last 6 months? _____

15. Approximate number of clients seen per contact. For example: a single client may be seen per contact; a family of three or four members may be seen as in conjoint counseling; ten persons may be seen as in group counseling, etc. If there are different modalities of service for clients, please explain these. _____

    A. Classroom contact would be one (1) contact with two (2) students.

    B. Family contact would be one (1) contact with as many family members as needed in therapy.

Part I

V. Staff Positions

A. Classroom Teacher

The classroom teacher will be a masters level teacher certified in emotional disturbances with at least three (3) years of related experience. Because the Community Based Class is an extension of Richard L. Sanders School, the classroom teacher will report directly to the Principal of Richard L. Sanders School. The primary responsibility of the classroom teacher will be to develop, implement and monitor an individualized educational and therapeutic program (ITEP). Based upon the dysfunctional behaviors identified through the referral process, the teacher will establish specific target goals and objectives. Rather than addressing the complete spectrum of appropriate behavioral skills, the Community Based Class teacher will concentrate on those behaviors that have been consistent with the student's inability to function appropriately in the SED Center. Although the primary concern of the classroom teacher is the improvement of the student's behavioral skills, the continuation of academic instruction is also a vital component in the curriculum of the Community Based Class Program. In order to facilitate the development of the program, the classroom teacher will be responsible for coordinating all educational and therapeutic activities with the mental health staff.

Other related responsibilities will include but are not limited to:

1. Development of academic goals and objectives;
2. Working with the mental health therapist to develop behavioral goals and objectives;
3. Participation in the development and revision of ITEP's;
4. Participation in all Community Based Class related staffing procedures;
5. Be responsible for and comply to all rules and regulations defined for Pinellas County classroom teacher.

B. Classroom Aide

The educational aide will report directly to the Community Based classroom teacher. The primary function of the aide is to provide assistance to the classroom teacher. The responsibilities of the educational aide include but are not limited to:

1. Clerical activities (use of office machines);
2. Preparation of classroom materials;
3. Working with audio-visual equipment;
4. Assisting with group or individual educational activities;
5. Assisting with group or individual therapeutic activities.

Part I

C. Mental Health Professional

The Mental Health Professional will be a Masters level Social Worker with at least three (3) years of related experience. The mental health professional will report directly to the Child Guidance Center of Mental Health Services of South Pinellas County. The primary responsibility of the mental health therapist will be to work in conjunction with the classroom teacher to develop the therapeutic component of the Community Based Class Program. A heavy emphasis will be placed upon involving the parents in the program through visits and telephone communications. Other duties will include but are not limited to:

1. Providing individual therapy to the identified client;

2. Providing group therapy to the identified clients;

3. Conduct regularly scheduled home visits;

4. Be available in the evenings to consult with the child or family staffed into the Community Based Class Program;

5. Providing parenting skills training;

6. Participation in the development and review of the ITEP;

7. Participation in all Community Based Class program placement procedures;

8. Crisis intervention.

Part I

MENTAL HEALTH SERVICES OF SOUTH PINELLAS, INC.

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Part I

VII. Prevention

Category number 3 was selected:

"3. Programs which address serious conditions, require long-term intervention, occasional limited separation of clients from their families, and provide for permanent transition between families."

The Community Based Class program will serve as an intermediate step in the continuum of care between SED Center based classrooms and more restrictive legal and/or residential options.

The Community Based Class program specifically addresses the needs of the severely emotionally disturbed student. Due to the severity of the clientele, long-term intervention in the community is anticipated. Separations of client from family, although not a component of the program will occur as a consequence of the behavior of the client in the community. The Community Based Class program will be flexible in accepting separation of client from the program. Through the mental health component, the family and client will be assisted in dealing with separations as they occur.

Although not a component of the program, helping to maintain a positive connection between client and family will be an unwritten activity.

BUDGET REQUEST

10/1/83 -- 9/30/84

FOR POSITIONS INDICATE FRINGE RATES

210 FICA _____ 211 RETIREMENT _____ 212 LIFE _____
213 WORK. COMP. _____ 214 UNEMPLOYEMENT _____ 212 HEALTH _____

	TOTAL BUDGET PERSONNEL ACCOUNT #110		ALLOCATION REQUESTED 10/1/83 -- 9/30/84		JWB APPROVED ALLOCATION 1982-83	
JOB TITLE (% OF TIME)	SALARY	FRINGE	SALARY	FRINGE	SALARY	FRINGE
1 - Mental Health Professional-Lv. I (9 mos., 180 days)	$11,874.00	$3,029.00	$11,874.00	$3,029.00		
1 - Classroom Teacher (221 days)	20,634.18	4,484.33				
1 - Classroom Aide, Entry Level (145 days)	4,200.00	1,611.00				
	$36,708.18	$9,124.33	$11,874.00	$3,029.00		
	TOTAL PROGRAM SALARIES	TOTAL PROGRAM FRINGE	SALARIES	FRINGE	SALARIES	FRINGE
	$45,832.51		$14,903.00			
	TOTAL PROGRAM SALARIES		TOTAL REQUEST SALARIES & FRINGE		TOTAL 1982-83 SALARIES & FRINGE	

ALL PROGRAM TOTALS ON DOUBLE LINES

119

COMPLETE PROGRAM - 1 -		TOTAL BUDGET 10/1/83-9/30/84 (9 mos.)-2-	ALLOCATION REQUESTED 1983-84 (9 mos.) -3-	JWB APPROVED ALLOCATION 1982-83 -4-
ACCT. #	OPERATING EXPENSES:			
310	Contractual Personnel*	2,430.00	2,430.00	
315	Accounting/Auditing	500.00		
320	Computer	100.00		
330	Travel (Other than Conf.)** @ 20¢ per mile (4000 miles)	800.00	800.00	
335	Conferences (including travel)	250.00		
345	Telephone ***	803.00 *	523.00	
350	Postage	50.00		
355	Electricity	incl. in rent		
356	Water/Sewer/Sanitation	incl. in rent		
357	Janitorial	incl. in rent		
360	Rental & Leases (Building) 306 sq. ft. @ $6.50/sq. ft.	1,492.00 (CYF)		
361	Rental & Leases (Equipment)	.00		
365	Insurance	141.00 (CYF)		
370	Repair & Maintenance Services	150.00	150.00	
371	Property Maintenance	250.00 (CYF)		
375	Printing	100.00		
376	Copying	75.00		
390	Office Supplies	50.00		
395	Operating Supplies	175.00		
401	Books	100.00		
402	Subscriptions/Memberships/Dues	N/A		
403	Other Educational Materials	1,000.00	500.00	
510	Food Nutrition	N/A		
515	Eligibles Title XX (Show Percent) *	N/A		
516	Ineligibiles Title XX	N/A		
520	Fixed Program Percent	N/A		
528	Care & Subsistence (Show cost per client & total)	N/A		

* Line 310: Psychiatric Time
45.00/hr 1.5 hr/wk = 67.50 wk.
67.50/wk x 4/wk = 270.00 mo.
270.00/mo x 9/mo = 2,430.00

** Line 330: Mileage for teacher aide and mental health professional

*** Line 345 -
337.00 installation
183.00 start-up
40.00 serv. charge
560.00
27.00/mo x 9=243.00 mo.

COMPLETE PROGRAM - 1 -		TOTAL BUDGET 10/1/83-9/30/84 (9 mos.)-2-	ALLOCATION REQUESTED 1983-84 (9 mos.) -3-	JWB APPROVED ALLOCATION 1982-83 -4-
ACCT. #	OPERATING EXPENSES:			
530	Recruitment (Soliciting of Clients)	308.92 ****		
537	After Care	N/A		
540	Tuition Deficit	N/A		
		8,744.92	4,403.00	
****	Based on an average per diem salary of 10 Pinellas County school professionals for 2 hours of consultation time.	Operating Expenses For Total Budget	Total Operating Expenses Requested	Total Operating Expenses Funded
		54,607.43	19,306.00	
		TOTAL PROGRAM BUDGET	TOTAL PROGRAM REQUEST	TOTAL JWB FUNDING 1982-83

BUDGET RECAP

OTHER SOURCES OF INCOME (Fees, Grants, etc.)

1. List all sources of significant funding.
2. Include total of sources providing at least 10% of total program cost or $5,000, whichever is the least, and list those sources in parenthesis.
3. Do not include volunteer services.
4. Please indicate whether income is allocated or projected.

OTHER SOURCES	10/1/83 - 9/30/84 INCOME ALLOCATED	10/1/83 - 9/30/84 INCOME PROJECTED	10/1/82 -- 9/30/83 INCOME ALLOCATED	10/1/82 -- 9/30/83 INCOME PROJECTED
School Board of Pinellas County	33,138.43			
CYF Funding	2,163.00			

$35,301.43

TOTAL OTHER SOURCES

TOTAL OTHER SOURCES

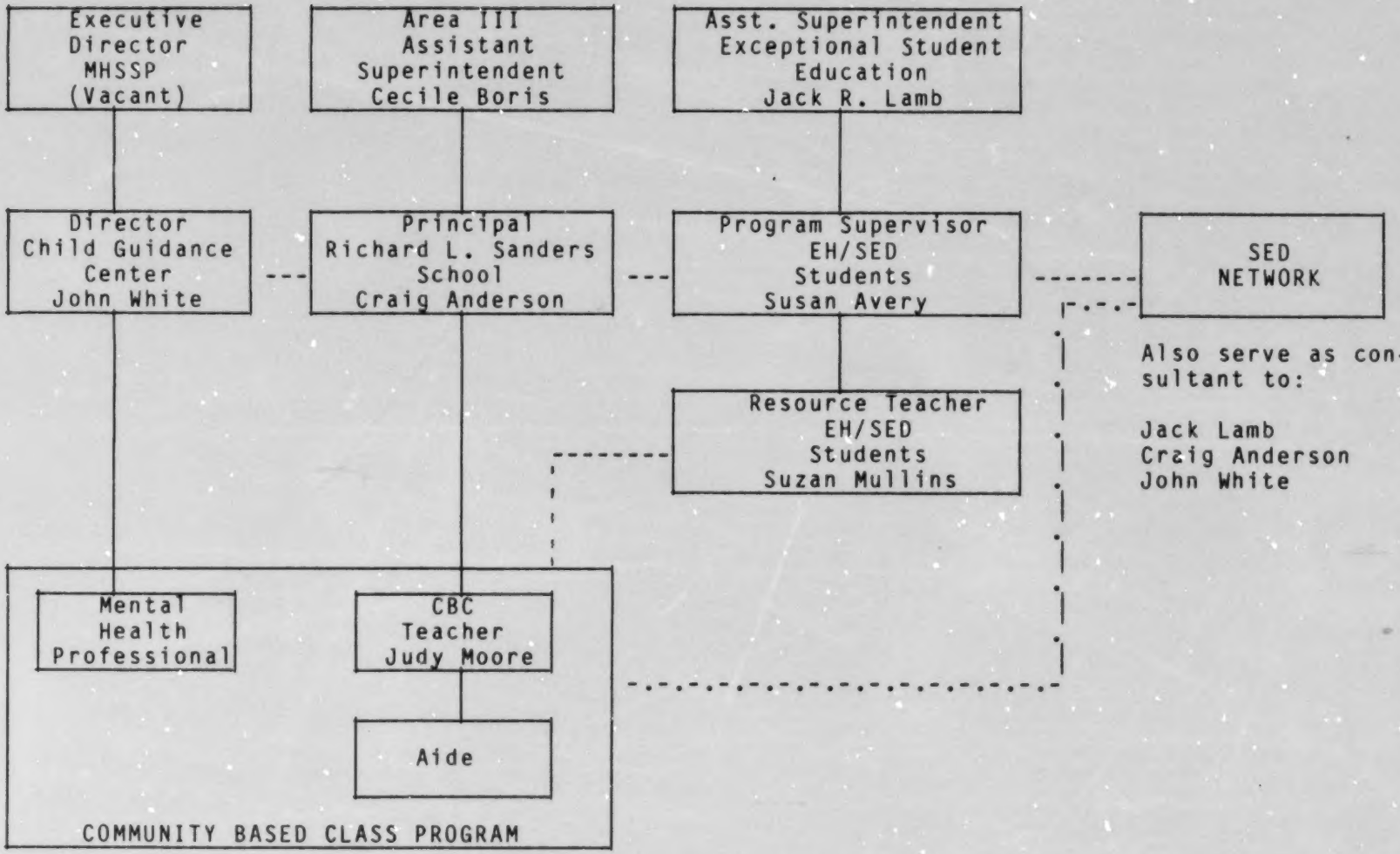
19,306.00

TOTAL FUNDING REQUESTED FROM JWB, FY 1983-84

54,607.43

TOTAL COST OF PROGRAM, FY 1983-84

142


Executive Director MHSSP (Vacant)
Area III Assistant Superintendent Cecile Boris
Asst. Superintendent Exceptional Student Education Jack R. Lamb
Director Child Guidance Center John White
Principal Richard L. Sanders School Craig Anderson
Program Supervisor EH/SED Students Susan Avery
SED NETWORK
Also serve as consultant to:
Jack Lamb
Craig Anderson
John White
Resource Teacher EH/SED Students Suzan Mullins
Mental Health Professional
CBC Teacher Judy Moore
Aide
COMMUNITY BASED CLASS PROGRAM
KEY: _____ Supervisory Responsibility
- - - - - - Line of Communication
.-.-.-.-.-. Consultation Role

SED NETWORK MENTAL HEALTH PROFESSIONAL INTERVIEW SURVEY

PURPOSE

The purpose of this survey was to determine the extent of involvement of mental health agencies with the Severely Emotionally Disturbed population of students in both Pinellas and Pasco County. There are approximately 250 students labeled Severely Emotionally Disturbed in both counties. The interview was developed to identify not only the extent of Mental Health involvement with SED students, but also to record concerns, needs and issues identified by the mental health professionals. The data gathered from the interview surveys supports trends, strengths and weaknesses of the Mental Health services in Pinellas and Pasco Counties specific to the SED population. An evaluation of the trends, strengths and weaknesses appear in the conclusion of this report.

PROCEDURE

Twenty-seven Mental Health professionals were individually interviewed. The Mental Health agencies involved in the survey were (1) Mental Health Services of South Pinellas County, Inc. (MHSSP), (2) Mental Health Services of Upper Pinellas County, Inc., (MHSUP), and (3) The Human Development Center of Pasco (HDC).

The following demographic information describes the Mental Health professionals interviewed. Each professional was assigned by their agency to work with children and their families.

Mental Health Professionals:

Therapists:	N = 25	N = 27 Male 10	Female 15
Supervisors:	N = 2	Male 0	Female 2
Degree:	BS 4	MA 19	Ph.D. 4
Degree Type:	Social Worker 23	Psychologist 3	Other 1
Licensed Therapists:	9		
Years of Experience:	6.4 years average		
Agencies:	Human Development Center 8		
	MHSUP 11	MHSSP 8	

MENTAL HEALTH SERVICES

OPERATIONAL INFORMATION: Content Analysis of Survey Questions

1. HOW ARE STUDENTS REFERRED TO YOUR PROGRAM?
2. FROM WHERE DO YOU RECEIVE MOST OF YOUR REFERRALS?

1 & 2: Mental health professionals depend to a large extent upon referrals for service from Health and Rehabilitative Services. Many other referrals were identified as coming from school districts (i.e., counselor or social worker) and relatives of clients. It is difficult to assess the actual origin of the referral because the referral procedure is often a "word of mouth" process. It is important to note that hospital referrals were much lower than anticipated.

3. WHAT METHODS OF EVALUATION DO YOU USE TO DETERMINE THE SEVERITY OF THE CLIENT?

The most prevalent method of evaluation used by the mental health professionals to determine the severity of the client was the use of a psycho/social history. Also widely used in the evaluation process was an informal interview of the parent. In appropriate situations, depending upon age and the presenting problems, the client would be interviewed either with or without parental interaction.

4. WHAT DIAGNOSTIC SERVICE DO YOU OFFER?

Both psychological and psychiatric evaluations were common diagnostic services provided through Mental Health Out-Patient Services. Several therapists indicated they relied upon the referral information as a source to determine the severity of the client.

5. QUESTION WAS DROPPED.

6. WHAT IS THE CRITERIA FOR ELIGIBILITY?

There appeared to be some confusion about criteria for eligibility for mental health out-patient services. The majority of the mental health professionals stated there was no criteria that a client needed to meet in order to qualify for services. However, most therapists indicated that the ability to pay for services on a sliding free-payment schedule as a necessary component. Although mental health therapists maintained that services would not be withheld if a client's family could not pay an established fee.

7. WHAT AGE OF CLIENTS DO YOU SERVE?

Therapists reported that the age of the clients who received services ranged from 0-18 years of age. A majority of the therapeutic services are provided to clients after the age of 3.

8. HOW DO YOU ASSESS THE PROGRESS OF EACH CLIENT?

When questioned about techniques used to assess the progress of each client, the mental health professionals' responses were varied. Most therapists depend upon their interaction with the client to determine if there is progress. Such techniques as (1) observing the client's coping skills, (2) talking with the client, and (3) observing the client's behaviors were the most commonly used tools to assess client progress. Other techniques cited as useful measurements of client growth included but were not limited to: (1) "gut feelings" of the therapist; (2) report cards and progress notes from school; (3) change in behavior of parents; and (4) formal testing.

8A. WHAT IS A TREATMENT PLAN? FROM WHERE DO YOU DRAW YOUR GOALS AND OBJECTIVES?

The Treatment Plan, which is comparable to the Individual Educational Plan (IEP) used in education, was identified as the primary planning tool used by out-patient therapists. Although the format of the Treatment Plan varied from one mental health agency to the next, all therapists interviewed revealed the need to determine specific goals and objectives for each client. These goals and objectives reflected specific behaviors that the therapist and or client identified as reasons for seeking mental health services. When reviewed from an educational perspective, where instructional objectives are both sequential and developmental, the sources from which mental health goals and objectives were drawn could be disputed. Mental health professionals responded that the objectives they developed for each treatment plan came by and large from "their head." Some therapists cited that they relied on the client or parent to actually tell them specific behaviors which needed remediation. Nowhere was an established sequential set of goals and objectives utilized or available to the mental health professional.

9. WHAT ARE YOUR PROCEDURES FOR DISMISSAL?

9A. WHAT IS THE CRITERIA FOR DISMISSAL?

Both criteria for dismissal and the dismissal procedures used by mental health therapists were informal and subjective. It was evident by the responses of the mental health professionals that a formal standardized procedure for dismissal does not exist within the Mental Health community. However, an extensive list of behavioral indicators used to determine dismissal readiness was compiled through this interview. The list included but was not limited to:

1) assessing client's ability to cope;
2) attainment of Treatment Plan goals
3) parental reports;
4) parent satisfaction;
5) completion of contracts;

It is important to note that many therapists do not dismiss clientsally after treatment, because the client often does not return after the initial visit. This is especially true of the severely emotionally disturbed population.

10. WHAT ARE YOUR FOLLOW-UP PROCEDURES?

Various methods of follow-up procedures are employed by mental health professionals. The most commonly used methods of formal follow-up on clients are (1) phone calls, (2) letters, and (3) talking with parent, teachers, and social workers. Twenty percent (20%) of the therapists felt there was no established formal follow-up.

11. WHAT SERVICES ARE PROVIDED TO THE CLIENT?
12. WHAT SPECIFIC CATEGORIES OF THERAPY ARE USED?

Mental health outpatient therapists provide clients with family, group, and individual counseling. Specific categories of therapy available to the client included but are not limited to:

1) Support Groups
2) Play Therapy
3) Developmental Play
4) Conjoint Family Therapy
5) Structural Family Therapy
6) Hypnosis

13. ARE THERE ANY AREAS OF MENTAL HEALTH SERVICE THAT YOU FEEL SHOULD BE PROVIDED BUT ARE PRESENTLY NOT AVAILABLE?

Mental health professionals identified the greatest need to be an increase in the number of parent groups and/or family therapy. Developmental Play, both as a therapeutic tool and as an in-service training program for therapists was seen as a high priority. Other programs viewed by mental health professionals as necessary services for the SED student included:

1) Summer recreational programs for SED students
2) Play therapy in SED Centers.

(A complete listing of program suggestions can be found in Appendix I.)

14. HOW FAMILIAR ARE YOU WITH THE CONTINUUM OF SERVICE AVAILABLE TO THE SED CLIENT THROUGH THE SCHOOL SYSTEM?

The interviews revealed that mental health professionals are more familiar with hospital services and adolescent day treatment programs than with the Pinellas and Pasco County's SED services. Only two (2) therapists had any previous knowledge of the SED Center Program in Pinellas County. However, the majority of therapists expressed an interest in learning more about these programs.

The interviews also revealed that only a third of the therapists who have a potential to work with a SED student have adequate information about residential facilities appropriate for this unique population.

15. WHAT IS THE EXTENT OF YOUR INVOLVEMENT IN SCHOOL-BASED SED PROGRAMS?

Mental health therapists have indicated that they not only have inadequate information about SED Centers but also have only a minimal involvement with the Center programs. More than fifty percent (50%) of the mental health therapists have had no interaction with the SED Centers. Involvement with the SED Center consisted of:

1) working with the school referral process;
2) telephone conversations;
3) SED Center classroom observations;
4) working with an SED student.

It is of significance to note that numbers 1-4 were single responses and may not be a true representation of mental health involvement with the SED Centers in Pinellas County.

16. HOW OFTEN DO YOU SEE THE CLIENTS?

Responses to this question were evenly distributed. The three answers that received nearly equal weighting were: (1) as often as needed, (2) once a week, and (3) twice a month.

17. HOW DO YOU ESTABLISH AND MAINTAIN COMMUNICATION WITH SCHOOL/HOME?

Therapists relied primarily upon telephone conversations to establish communication with schools and homes. Other forms of communication with the school and home included but are not limited to:

1) visitations;
2) conferences;
3) use of Release of Information Forms.

18. WHAT ARE YOUR SUGGESTIONS FOR IMPROVING COMMUNICATION WITH SCHOOL/HOME?

A majority of the therapists felt that communications with the school and home were adequate. No suggestions were offered for improving communication lines. However, the need for an individual liaison between each school and the mental health agency was viewed as an essential component for consistent communication. It may be inferred from the wide range of responses, that most therapists are comfortable with their individual forms of communication with specific school district employees.

19. HOW DO YOU ESTABLISH AND MAINTAIN INTERAGENCY COMMUNICATION?

As reported in establishing home/school communication, therapists depended upon telephone conversations as the primary communication tool. Most therapists indicated that communication among other agencies remained informal with no established procedures for communication. A few mental health professionals considered HRS to be the linkage agency with all other community agencies. Many therapists expressed concern about communication breakdowns in the areas of:

1) hospital discharge procedures;
2) hospital clients who are referred to mental health out-patient services;
3) hospitalized clients who return to the public school system.

20. WHAT ARE YOUR SUGGESTIONS FOR IMPROVING INTERAGENCY COMMUNICATION?

Most therapists had no suggestions for improving interagency communication. Some respondents suggested that Mental Health services would benefit from an information and referral manual that outlined the criteria for placement in public service Student Exceptional Education Programs. Other suggestions for improving communication included but were not limited to:

1) using a standardized form for referrals;
2) increased administrative support;
3) securing a Release of Information Form from parents or guardians;
4) including agency names on Individual Education Plan (IEP).

21. DOES THE AGENCY OFFER IN-SERVICE TRAINING?

All of the mental health professionals responded that in-service training was provided by their agency.

22. IF SO, WHAT TYPE?

Mental Health Services in both Pinellas and Pasco Counties offer in-service training to all staff. The most prevalent method of training reported was through the use of Clinical Staff meetings. In-service training provided by the Juvenile Welfare Board (J.W.B.) of Pinellas County was also viewed as an effective training program. Other sources for in-service training of Mental Health professionals included but were not limited to:

1) individual presentations;
2) staff suggested topics;
3) Florida Diagnostic Learning & Resources System (FDLRS)
4) Pinellas and Pasco School Districts;
5) Interagency participation.

23. IN REFERENCE TO LICENSING AND LICENSING RENEWAL, ARE COMPONENT POINTS GIVEN FOR ATTENDING WORKSHOPS AND IN-SERVICE TRAINING?

The majority of therapists surveyed had received component points for in-service training. There appeared to be a lack of understanding among therapists as to the appropriate use of these component points for licensing and licensing renewal. This is evident by the number of therapists who responded that (1) they did not know what component points were, (2) they did not know what to do with them, and (3) they had not even heard of component points.

24. WHAT TYPE OF WORKSHOPS AND IN-SERVICE TRAINING WOULD BE BENEFICIAL TO YOU IN WORKING WITH SED CLIENTS?

The workshop that received the most favorable response was Developmental Play Training. Other workshops that were noted as necessary for working with the SED client included but were not limited to:

1) A better understanding of the Emotionally Handicapped, Severely Emotionally Disturbed programs in Pinellas/Pasco County School Districts;
2) Hospital programs for Emotionally Handicapped/Severely Emotionally Disturbed Clients (EH/SED);
3) Family Therapy;
4) Individual Education Program (IEP) information;
5) Therapeutic approaches for the resistant adolescent;
6) Identification and referral process for Emotionally Handicapped/Severely Emotionally Disturbed clients within the school districts of Pinellas/Pasco Counties;
7) Hypnosis;
8) HRS services;
9) Tour of an SED Center;
10) Parenting skills.

(See a complete listing of program suggestions in Appendix I.)

25. HOW FAMILIAR ARE YOU WITH THE IEP?

Sixteen (16) mental health professionals responded that they had heard of the Individual Education Plan (IEP). However, less than half of that number had actually participated in the development of an IEP. Fourty-eight percent (48%) of the mental health therapists had provided information for the writing of an IEP.

25A. AS A CLINICIAN, WHAT DO YOU SEE AS A DEFINITION OF AN SED CLIENT?

When asked to provide a definition of a Severely Emotionally Disturbed client, mental health professionals relied upon:

1) observable behaviors;
2) inferential behaviors;
3) clinical considerations;
4) perceived needs of the client.

Observable behaviors are those types of behaviors overtly exhibited by the client. Such phrases as (1) "acts out physically," (2) "destructive to self and property," and (3) "lack of impulse control," were mentioned. Inferential behaviors were behaviors of the SED client that mental health professionals identified either through direct interaction with the client or indirectly through parents, school system or other agencies involved with the client. Typical responses were (1) dysfunctional family, (2) poor relationships with peers and authority figures, and (3) low self-concept. Clinical considerations dealt with the medical aspect of providing service to the SED client. Such items as (1) psychotic symptoms, and (2) severe psychiatric labels surfaced. The fourth category that mental health professionals used in a definition of the SED client was to identify perceived needs of the client. Descriptors most often used included:

1) a need for structure and
2) emphasize social skills.

(A complete list of phrases, terms and behaviors used by the mental health professional to develop a definition of the Severely Emotionally Disturbed client is contained in Appendix I.)

26. HOW MANY SED CLIENTS DO YOU SERVE?

The overall response from the mental health professional was difficult to assess because the SED category is an educational term rather than a mental health term. Most therapists approximated serving only 1 or 2 clients that could be considered severely emotionally disturbed. There exists no formal record keeping system or case management system for children with severe emotional handicaps. Due to this, it was impossible to arrive at an exact number of SED school-aged clients receiving mental health services in either Pinellas or Pasco Counties.

27. WHAT IS YOUR PERSONAL ATTITUDE TOWARD THE SED CLIENT?

The most consistent response given by the mental health professional was an expression of concern about the necessity of continuing therapy from childhood into adult life. The SED population was considered to be a perplexing, often resistent group to provide therapy on an out-patient basis.

CONCLUSIONS:

Data gathered from the survey of mental health professionals in Pinellas and Pasco Counties revealed numerous concerns and issues relevant to providing quality services for SED school-aged children. The following is a comprehensive representation of these needs and concerns.

1. Mental health therapists have only a minimal understanding of the public school's referral and placement procedure for children in exceptional education.

2. Mental health therapists have a need for an information and referral manual that would provide information about all exceptional educational programs in Pasco and Pinellas County School Systems.

3. Mental health therapists are not familiar with SED Center Prorams in Pinellas County.

4. In reviewing the multitude of definitions, descriptors, and behaviors used by mental health therapists to identify the SED student, it is evident that no consistent definition of the SED student exists.

5. There appears to be no consistent formal dismissal and follow-up procedures for the SED client involved in Mental Health Services.

6. There is no formal case management system for SED children and youth served through Mental Health Services.

7. Mental health therapists recognize the need to seek alternate forms of therapy for treatment of the SED client. Traditional therapies used n the treatment of most clients are often ineffective and inappropriate for the SED population.

8. Mental health therapists appear to be serving only a fraction of the SED population identified in Pinellas and Pasco Counties.

9. There is a lack of coordination of services between hospital programs for SED students and out-patient Mental Health Services.

10. Most mental health therapists expressed a willingness to attend in-service workshops dealing with:

    1) clinical approaches and therapies for the SED clients and
    2) specific SED programs provided by the public school system.

RECOMMENDATIONS:

1. Mental health therapists who have the potential to become involved with the SED student would benefit from information about the public school systems referral and placement procedure for exceptional students. This could be provided through in-service workshops or through an information and referral manual.

2. An information and referral manual needs to be developed that would briefly explain to professionals in education and mental health specific exceptional student education programs available in both Pinellas and Pasco County. This manual should include (1) a definition of the program, (2) criteria for eligibility, (3) contact person, and (4) referral procedure.

3. Mental health therapists need to be provided with in-service training that would familarize these professionals with the SED Center concept.

4. A definition for SED needs to be developed that is acceptable by both the mental health profession and the education profession.

5. A formal dismissal and follow-up procedure needs to be developed for use with SED school-aged children involved with Mental Health Services.

6. A case management system for SED children and youth served through Mental Health Services needs to be developed.

7. Alternate forms of therapy to be used with the SED population needs to be explored and these options made available to mental health professionals.

8. In order to serve a greater number of the SED students, Mental Health Services need to be available at each center. This could be achieved through the contracting of full-time mental health professionals at each center. (A cooperative agreement between Mental Health Services and the local school board would need to be developed as a means of providing a therapeutic component in the SED Center.)

9. Hospital Services for the SED population need to establish specific procedures for:

   1) communicating with Mental Health Services specifically

      a) discharging of patients
      b) release of patient information to Mental Health Service

APPENDIX I

I. Observable Behaviors

a) Shows no respect for authority
b) Acts out physically
c) Low self-concept
d) Lacks impulse control
e) Resistant to change
f) Extreme behaviors
g) Lacks age-appropriate behavior
h) Can not focus energy
i) Client does not consider consequences of behavior
j) Unhappy most of the time
k) Self-destructive
l) Destructive to property
m) Can not trust people
n) Students emotionality overrides their ability to learn

II. Inferential Behavior

a) Poor relationships with peers and authority
b) Dysfunctional Family
c) Poor social skills
d) Do not rely on the diagnostic label
e) Poor ego regulation
f) Difficult kid
g) Live for the moment
h) Cannot focus energy
i) Low self-concept
j) Resists change
k) Unhappy

III. Clinical Considerations

a) Psychotic symptoms
b) Has severe psychiatric label
c) Length of presenting problem
d) Inadequate coping skills
e) Their reality does not match your reality

IV. Perceived Needs of Students

a) Benefits from structured settings
b) Emphasis on social skills
c) One-to-one instruction
d) Consistency

APPENDIX II

1. HOW ARE STUDENTS REFERRED TO YOUR PROGRAM?

Schools	8
HRS	8
Friends/Relatives/Parents	8
Hospital	4
Social Worker	3
Counselor	3
Residential Placement	3
Self Referral	2
Principal	2
Physician	1
Juvenile Justice System	1
Teacher	1

2. FROM WHERE DO YOU RECEIVE MOST OF YOUR REFERRALS?

Schools	8
HRS	8
Friends/Relatives/Parents	8
Hospital	4
Social Worker	3
Counselor	3
Residential Placement	
Self Referral	2
Principal	2
Physician	1
Juvenile Justice System	
Teacher	

3. WHAT METHODS OF EVALUATION DO YOU USE TO DETERMINE THE SEVERITY OF CLIENT?

Social History	11
Psychiatric/Psychological Evaluation	8
Parent Interview	6
Referral Information	4
Client Interviews	
Inventory	2
Mental Statis	2
Projectives	2

4. WHAT DIAGNOSTIC SERVICE DO YOU OFFER?

Psychiatric	16
Psychological	8
Functional Assessment Review (FAR)	1

5. DROPPED DUE TO CONFUSION OF QUESTION.

6. WHAT IS THE CRITERIA FOR ELIGIBILITY?

None	14
Sliding Fee (pay)	6
Under 18 (age)	5
Not care for self	1
Threat to self/property	1
Dysfunctional in family or school	1
Severe depression	1
Don't know	1
Court or HRS ordered	1

7. WHAT AGE OF CLIENTS DO YOU SERVE?

0 - 18 yrs.	10
2 - 18 yrs.	3
3 - 18 yrs.	4
3 - 17 yrs.	0
13 - 17 yrs.	3
2 - 10 yrs.	1

8. HOW DO YOU ASSESS THE PROGRESS OF EACH CLIENT?

Observation of Behaviors	8
Interview with Client	7
Observation of Coping Skills	4
Evaluation of Treatment Plan	4
Personal Bias	2
Evaluation of Appropriate Emotional Content	2
Evaluation of Report Card Progress Notes	2
Evaluation of Change in Parents Attitude	2

8A. WHAT IS A TREATMENT PLAN? FROM WHERE DO YOU DRAW YOUR GOALS AND OBJECTIVES?

A treatment plan is written at intake of client. Goals and objectives are determined relevant to the presenting problem. (Typical response) Frequently parents determine what it is they want changed in their child.

8B. FROM WHERE DO YOU DRAW YOUR GOALS AND OBJECTIVES?

Professional experience/clinical judgement	12
Interviewing client	6
Interviewing parent	2

9. WHAT ARE YOUR PROCEDURES FOR DISMISSAL?

How well the client is coping?	6
None	3
Establish criteria	3
Clients drop out	3
(Parent) Satisfaction	4
Interview client	2
Completed contracts	2
Through (Re) Evaluations	1
Time frame met	1

9A. WHAT IS THE CRITERIA FOR DISMISSAL?

Client drops out	7
Goals reached	5
Ability to function improves	5
Report from parent	4

10. WHAT ARE YOUR FOLLOW-UP PROCEDURES?

FORMAL		INFORMAL	
Phone call	6		
Letter	4	3	None 5
Case review open	3		
Talk to parents/ teachers	2		

11. WHAT SERVICES ARE PROVIDED TO THE CLIENT?

Individual therapy	17
Family therapy	16
Group therapy	12

12. WHAT SPECIFIC CATEGORIES OF THERAPY ARE USED?

Conjoint Family Therapy	3
Structural Family Therapy	2
Psychotherapy	2
Reality	1

12. (continued) WHAT SPECIFIC CATEGORIES OF THERAPY ARE USED?

Behavior Modificationpy	1
Support Group	12
Play therapy	6
Developmental Play	5
Hypnosis	2
Individual Family Therapy	1
Reality	1
Staff therapy	1

13. ARE THERE ANY AREAS OF MENTAL HEALTH SERVICE THAT YOU FEEL SHOULD BE PROVIDED BUT ARE PRESENTLY NOT AVAILABLE?

Parent Education groups	5
Summer School SED	2
Family Therapy	4
Developmental Play	3
SED Kindergarten	2
Support Groups	2
Adolescent Groups	2
Preschool SED	1
Social Maintenance Group	1
Staff Therapy	1
Inservices	2
PR - Mental Health Services	1
Constant Nurturing	1
Home visits	1
Relax Therapy	1
Inschool Groups	1
Play Therapy	2

* No Mental Health Professional indicated a need for therapist in a center.

14. HOW FAMILIAR ARE YOU WITH THE CONTINUUM OF SERVICE AVAILABLE TO THE SED CLIENT THROUGH THE SCHOOL SYSTEM?

Adolescent Day Treatment Program (ADTP)	10
Hospital	10
Resident	7
Center Program	2

15. WHAT IS THE EXTENT OF YOUR INVOLVEMENT IN SCHOOL BASED SED PROGRAMS?

None	15
Observed the class	1

15. (continued) WHAT IS THE EXTENT OF YOUR INVOLVEMENT IN SCHOOL BASED SED PROGRAMS?

Telephone Interview	1
Referrals	1
Worked with students	1

16. HOW OFTEN DO YOU SEE THE CLIENT?

Once a week	6
Twice a month	6
As often as needed	5
Daily	1
Twice a week	1

17. HOW DO YOU ESTABLISH AND MAINTAIN COMMUNICATION WITH SCHOOL/HOME?

Call	12
Visit	3
Release of Information	2
Conference	2
Spies	1
Bus Driver	1
Poor	1
None	1

18. WHAT ARE YOUR SUGGESTIONS FOR IMPROVING COMMUNICATION WITH SCHOOL/HOME:

None	8
Liaison School	3
Establish Communication System	11
Call parents at work	1
Court Ordered	11
Parent Contract	1
Probation	1
HRS	1
Phone	1
Inservice	1
Guidelines for Community	11
Support staff/school	1

19. HOW DO YOU ESTABLISH AND MAINTAIN INTERAGENCY COMMUNICATION?

Phone	10
Nothing	4
HRS	3
Good	1
?	1
Informal	1

20. WHAT ARE YOUR SUGGESTIONS FOR IMPROVING INTERAGENCY COMMUNICATION?

No suggestions	15
Need Criteria for placement	2
HRS forms for referral	1
Administrative support	1
Release of information	1
Agency name on IEP	1
List of contacts	1
Staff Development	1

21. DOES THE AGENCY OFFER IN-SERVICE TRAINING?

Yes	27
No	0

22. IF SO, WHAT TYPE?

Clinical staff meeting	5
Inhouse	2
JWB	3
Program Center Schools	1
Interagency	1
Parent Education	1
Presentations	2
All types	1
Sexual abuse	1
FDLRS	1
Staff suggestions	2

23. IN REFERENCE TO LICENSING AND LICENSING RENEWAL, ARE COMPONENT POINTS GIVEN FOR ATTENDING WORKSHOPS AND IN-SERVICE TRAINING?

Yes	14
Don't Know	6
Sometimes	2

24. WHAT TYPE OF WORKSHOPS AND IN-SERVICE TRAINING WOULD BE BENFICIAL TO YOU IN WORKING WITH SED CLIENTS?

Developmental Play	7
SED/SLD/EH Program Information	6
Hospital Information	4
School Operation	2
Family Therapy	2
Working IEP	2
Hypnosis (relaxation)	2
Social History	1

24. (continued) WHAT TYPE OF WORKSHOPS AND IN-SERVICE TRAINING WOULD BE BENEFICIAL TO YOU IN WORKING WITH SED CLIENTS?

Alternative Education Information	1
Operation PAR	1
Vocational Education	1
Treatment Issue	1
Sex Abuse	1
Parent Education	1
Information on MHS	1
Therapy with resisting adolescent	2
Information about ITCH Programs	1
Experiential Group	1
Teaching Modalities	1
Play Therapy	1
Information on Identification and Referral Procedures into Exceptional Student Instructional Programs	2
Educating regular teachers about SED students	1
Citizen Dispute	1
Group homes	1
HRS	3
Identification of Problems	1
Presentation on FIT	1
Parenting Skills	2
Various therapies	3
Mental Health/School Relations	1
Mental Health Center Services	1
Tour of SED Program	3

24. (continued) WHAT TYPE OF WORKSHOPS AND IN-SERVICE TRAINING WOULD BE BENEFICIAL TO YOU IN WORKING WITH SED CLIENTS?

Neurological functioning	1
Day Treatment	2
Identification and Referral	1

25. HOW FAMILIAR ARE YOU WITH THE IEP?

Heard	16
Provided	12
Participate	7

25A. AS A CLINICIAN, WHAT DO YOU SEE AS A DEFINITION OF A SED CLIENT?

Severe Behavior
Assaultive
Difficulty in Problem Solving
Reality difficulties
Difficulty assuming responsibility
Poor self esteem
Poor peer relations
Difficulty trusting people
Often rejected
Self Destructive
Self destructive to property
Duration of Problem
Student's Emotional Difficulty disrupts other student's learning
Poor Social Skills
Student's Emotionality effects ability to learn
Poor Interpersonal Skills
"Live - for the moment"
Unhappy all the time
Behavior with non consequences
Upset by not getting needs met
Poor sense of who they are
"Extremely difficult time focusing Energy"
List of Behavioral Characteristics (SEE APPENDIX II)

26. HOW MANY SED CLIENTS DO YOU SERVE?

General response - few - very few
Identified or seen (1-2 average response)

27. WHAT IS YOUR PERSONAL ATTITUDE TOWARD THE SED CLIENT?

Will need adult treatment	9
Difficult	2
Crazy Group	

SED NETWORK & DISTRICT V
CASE MANAGEMENT SYSTEM DEVELOPMENT PROCESS

INTRODUCTION

Service providers in HRS District V have identified case management services as a high priority for children and adolescents. The population in most need of case management services are those children identified as severely emotionally disturbed (SED). Currently, the District V Case Review Committee (CRC) appoints a case manager for children screened for state hospitalization or local treatment. The appointed case manager may be a psychologist, Community Mental Health Center (CMHC) therapist, Health & Rehabilitative Services counselor or other community professional. Case management, unfortunately, becomes a low priority as therapeutic and other work loads demand the professional's attention. Advocacy for the client becomes limited to the confines of the agency which employs the CRC assigned Case Manager. Community-wide advocacy, a time consuming task, is usually not a common practice for even the most severely disturbed child.

Treatment resources available to the SED population are limited and should be provided in concert with other ancillary community services that enhance the effects of treatment. Many times a contributing factor to the abnormal behavior of the SED child is their environment. The home situation can be improved by linking the child's family with appropriate services. Parents in many cases are unfamilar with available services. They are not always emotionally prepared to or fully understand which services to seek. Treatment for a school aged SED child requires a coordinated effort among the school, mental health system, parents and the community. In many cases, the Juvenile Justice System is also involved with the child. All too often, the SED child is not given consideration for having a severe handicap and is incarcerated and denied the necessary treatment.

A case management system designed to address the special needs of the SED child and his/her family is needed to assure continuity of care and to improve the quality of life for all parties. Case management can encourage more appropriate use of services for SED children as well as advocate for the creation of new and/or improved services.

A major consideration in the provision of treatment services to school aged SED children is the integration of education and therapeutic components. The diverse orientations of educators and mental health professionals sometimes result in different opinions on "What is best for the child." Present ties between the two systems are becoming strengthened by the recent award to District V of a multiagency network project which includes both education and mental health services.

The SED Network is funded by State Department of Education discretionary monies allocated under Public Law 94-142, the Education for All Handicapped Children Act of 1975. The project is designed to improve the level and quality of services for severely emotionally disturbed children and youth by fostering multiagency cooperation and communication. The SED Network acts as a catalyst for the community to fill service gaps in the continuum of mental health and educational services to children with severe emotional/behavioral disorders.

The Case Management System Development Committee (CMSDC), a task group of the SED Network, has been formed to develop a case management system in District V. The CMSDC is comprised of representatives from the Pinellas and Pasco school and mental health systems, hospitals, day treatment programs, Health & Rehabilitative Services, District Mental Health Board and Mental Health Association.

The CMSDC has identified many issues associated with the development and implementation of a Case Management System for SED children (see appendix). The first major issue identified by the Committee is the development of a concise and widely acceptable definition of case management and case management functions. The definition will form the foundation upon which the District V Case Management System will be designed.

In addition to the creation of a definition of Case Management, discussion must occur between school and mental health professionals to determine how best to integrate the case manager role with that of the SED classroom teacher. This blending of the two roles will be a key to successful mainstreaming of the SED student. These and other issues are presently being discussed by the CMSDC. A cooperative attitude has developed during the meetings. This multiagency process will result in the development of a case management system that will assure the health and well being of SED children in District V.

CASE MANAGEMENT SYSTEM DEVELOPMENT

Several significant meetings of the CMSDC have occurred. As a result of these meetings, SED Network staff have initiated research activities and have developed a definition of Case Management. The definition is based upon extensive reviews of the current Case Management literature. The majority of the literature is oriented to development or definition of Case Management systems for the chronically mentally handicapped adult. Relatively little research has been done defining Case Management functions and activities for children.

In an effort to make the new definition of Case Management universal, no specific population has been selected. The definition outlines functions and activities germane to all age groups.

The attached information was developed for the CMSDC to review and critique. Based on the committee's input. Modifications to definitions are anticipated. A truly multiagency/multidisciplinary process is being used to develop the definitions of Case Management.

Further research and additional meetings of the CMSDC are scheduled. Issues defined by the Committee will be addressed as the entire Case Management system is designed by the Committee. The advantage of this type of developmental process is that the community professionals developing the system are the same professionals that will implement the system. The definition presented here is in rough draft form.

CASE MANAGEMENT DEFINITIONS

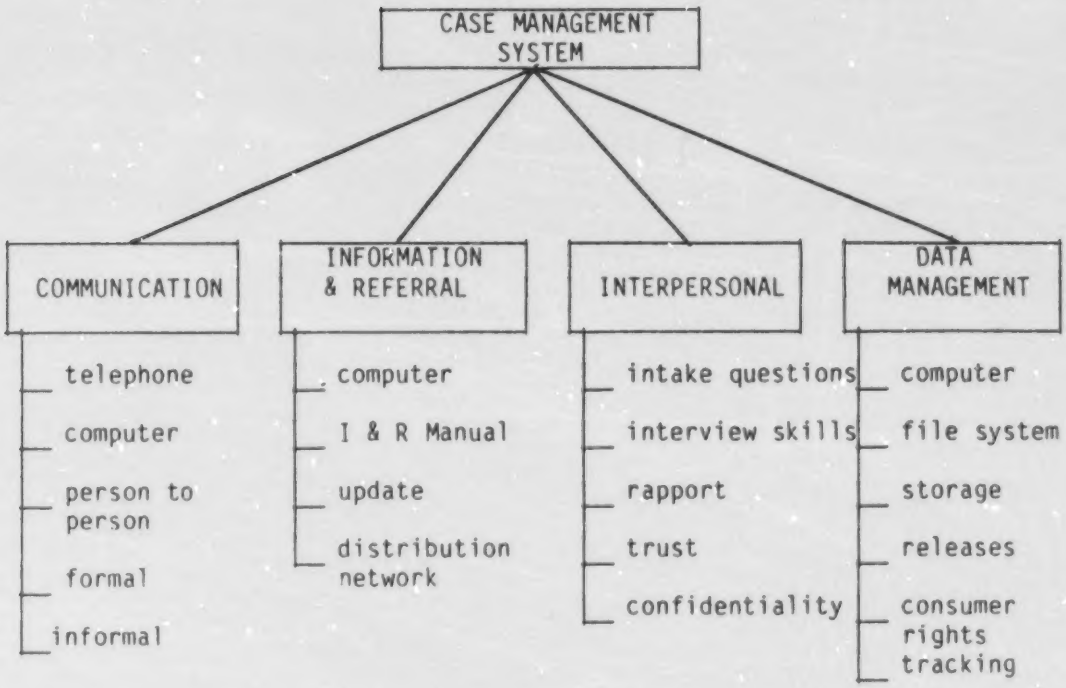
I. CASE MANAGEMENT IS A SYSTEMATIC PROCESS OF ADVOCACY TO PRODUCE AN IMPROVEMENT IN THE QUALITY OF LIFE* OF THE CONSUMER.

II. A CASE MANAGER IS AN ADVOCATE FOR THE CONSUMER IN BOTH AN INDIVIDUAL AND SYSTEM-WIDE CAPACITY.

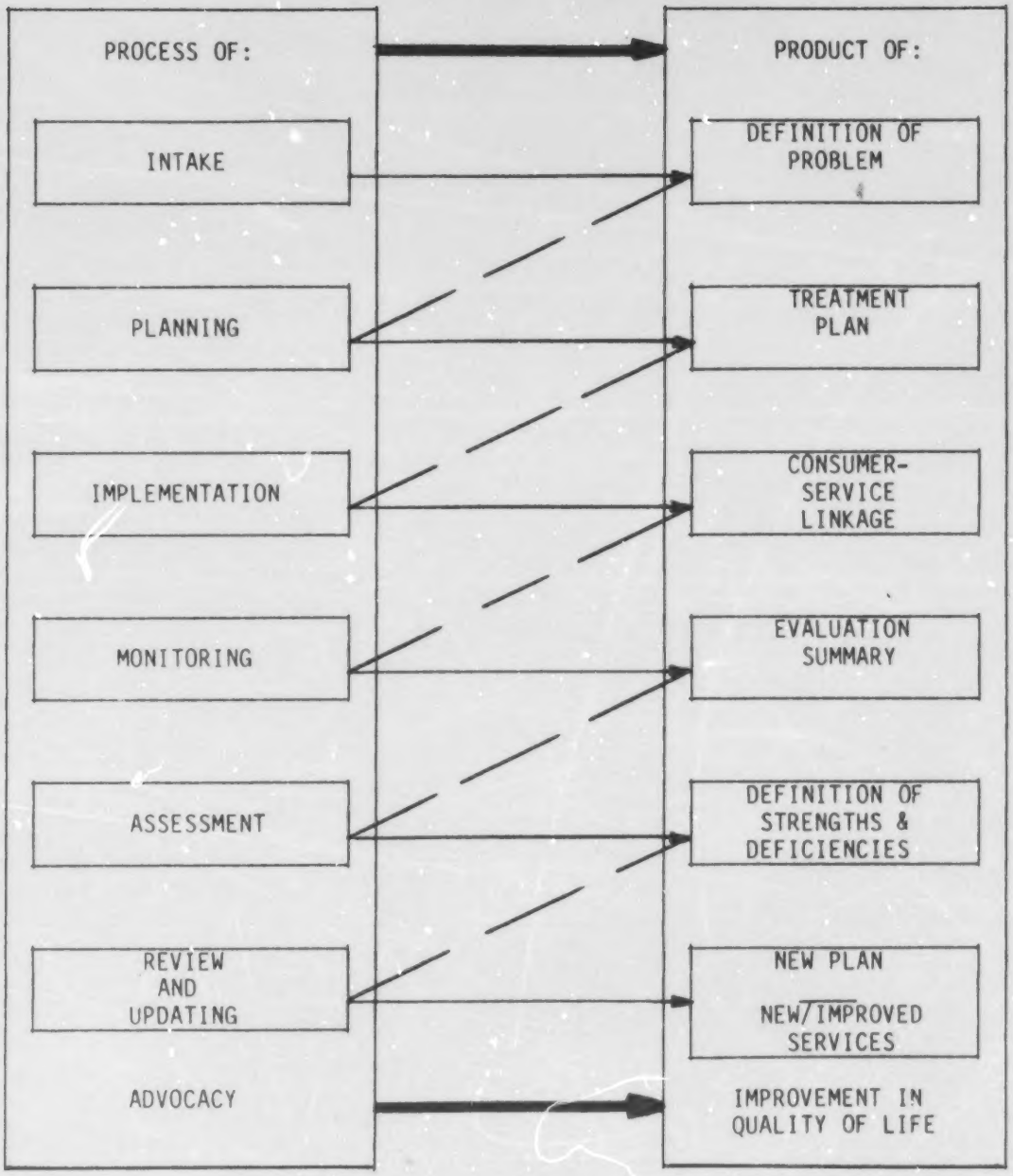
III. A CONSUMER IS THE IDENTIFIED USER OF CASE MANAGEMENT SERVICES. ALTHOUGH THE CONSUMER IS AN IDENTIFIED INDIVIDUAL, MEMBERS OF THEIR FAMILY MAY BE INVOLVED WITH OR BENEFIT FROM CASE MANAGEMENT SERVICES.

* QUALITY OF LIFE is descriptive terminology referring to certain changeable characteristics that define the consumer's manner of life.

IV. A CASE MANAGEMENT SYSTEM IS THE INTEGRATED LINKAGE OF COMMUNICATION, INFORMATION AND REFERRAL, INTERPERSONAL, AND DATA MANAGEMENT SYSTEMS.



V. CASE MANAGEMENT FUNCTIONS



VI. CASE MANAGEMENT ACTIVITIES

There are three basic types of case management activities:

Internal: The development and maintenance of a documentation, recording and filing system for client information. The maintenance of a clinical record is an example of an internal case management activity.

System: Activities conducted by the case manager to substantially influence the service system to increase the service delivery to the consumer. Advocacy for new or improved services is an example of a system case management activity.

Consumer: These are a set of activities geared toward the benefit of the consumer. They included case manager-to-client contact and case manager activities in developing consumer-service linkages. The intake interview is an example of a consumer case management activity.

CASE MANAGEMENT ACTIVITIES: FURTHER DEFINED

A. INTAKE

1) Eligibility determination for free and fee services
2) Clinical eligibility
3) Multi-problem care
4) Determine need for more extensive diagnosis and/or evaluation
5) Need for a diagnosis
6) Collect data from family/others
7) Review forms/permission, etc.

DEFINITION OF PROBLEM

1) Definition of presenting problem (stated in writing)
2) Diagnosis (if possible or appropriate)
3) Financial status determined
4) Paper work completed

B. PLANNING

1) Examine existing information
2) Determine types of services necessary
3) Review information and referral manuals, etc.
4) Define treatment goals, long and short term
5) Define treatment objectives

TREATMENT PLAN

1) Written treatment plan
2) Listing of service agencies based on treatment plan

C. IMPLEMENTATION

1) Select service providers
2) Establish contact with service providers

   a) telephone
   b) letter
   c) personal
   d) other system

3) Initiate schedule of visits by consumers
4) Determine service providers contact person

CONSUMER-SERVICE LINKAGE

1) Client-service linkage
2) Written documentation of appointments, locations, contact persons

D. MONITORING

1) Client oriented activities

   a) appointments kept, cancelled, etc.
   b) client satisfaction of service provider intake
   c) assessability of services
   d) collection of information about appropriateness of services offered to consumer
   e) data collection about usefulness of service to consumer (survey, etc.)

2) System oriented activities

   a) waiting lists
   b) intake procedure
   c) evaluation data on consumer use of services
   d) receptiveness of consumer to service
   e) data collected as to available service types based on consumer need

EVALUATION SUMMARY

1) Evaluation summary (written) of:

   a) client oriented activities
   b) system oriented activities

   based on above data collection

E. ASSESSMENT

1) Review of evaluation summary of <u>client oriented</u> results of consumer-service linkage:

   a) detail positive results of consumer-service linkage
   b) detail negative results of consumer-service linkage

2) Review of evaluation summary of <u>system oriented</u> results of consumer-service linkage:

   a) detail positive results of consumer-service linkage
   b) detail negative results of consumer-service linkage

DEFINITION OF STRENGTHS & DEFICIENCIES

1) Definition of consumer-service linkage strengths (consumer oriented)
2) Definition of consumer-service linkage deficiencies (consumer oriented)
3) Definition of consumer-service linkage strengths (system oriented)
4) Definition of consumer-service linkage deficiencies (system oriented)

F. REVIEW AND UPDATING

1) Evaluate the effectiveness of the established treatment plan and/or sub-goals and objectives
2) Evaluate consumer's use of services and effectiveness
3) Evaluate consumers commitment to using services provided
4) Evaluate need for

   a) improved service
   b) new service

NEW PLAN

1) Return client to intake for re-evaluation of presenting problem and re-introduction into planning process
2) Encourage system to develop improvements in present services
3) Encourage system to develop new services

Appendix

CASE MANAGEMENT
System Development Committee

Issues Discussed at
September 7, 1983 Meeting

1. Definition: Although definitions of case management exist (reference JCAH document), the practice of case management by school and mental health is significantly different based on the different perspectives of the practitioners.

2. Cross System: One child or family may be effectively serviced within an agency, but difficulties arise when the case goes to another agency for services while still receiving services from the first agency.

3. Parallel Case Management: As the client enters a new system, they may be assigned a new case manager representing the agency's services. Therefore, one client may have many assigned case managers.

4. Who is Responsible: With many case managers, who is most responsible for the client at any given point in the system.

5. "Buck" Passing: Because many case managers are involved, when one completes their involvement, they could drop the case. Other case managers may not know to pick up the case. Therefore, lack of continuity of care results.

6. Communication: Confused, a client may hear different "stories" from each of their different case managers.

7. Time: Both school and many mental health workers have very little time to do effective case management.

8. Teachers: SED teachers, called case managers, may have to ask others, re: social worker, to carry through on case management activities.

9. Hospital: Unannounced or unanticipated discharge of client back into school or mental health system. No or little discharge planning. Case Managers not informed by Doctors of plans.

10. Hospital Follow-up: Occasionally, few follow-up activities occur. A client may be without an active case manager because of communication problems.

11. Follow-up: Case is followed by mental health during contact but may not be followed after discharge due to lack of manpower and other resources.

12. Mental Set: Case Managers' attitudes toward case management may affect their effectiveness in conducting case management activities.

13. Roles: Practitioners who see role as case manager or who enjoy case management, tend to do more and better job.

14. Legislation: Mandates by legislation and/or agency philosphy create parallel systems that don't always interact to the client's benefit.

15. Funding: Although case management is mandated, little resources are allocated for personnel. Case management appears to be done more on an "as needed basis", rather than consistently planned and executed.

16. Information and Referral: Alternative Human Services offers extensive I & R services. Approximately 25 percent of 20,000 calls for I & R were placed by professionals last year. I & R is a basic part of case management activities.

17. Case Review Committee: Case Management is an active part of CRC referring. Committee may serve to further develop District V case management system.

At present, the following activities under heading of Case Management appear to be occurring:

School System: SED Teachers are designated as case managers. Their primary function is teaching in the classroom. School support staff may actually be doing limited case management in traditional sense.

Mental Health: For undefined population of children, case managers primarily provide therapy. For defined children's population (1. Those in state hospital; 2. Those hospitalized 2 or more times; 3. High Risk (need more restrictive placement)) case manager does primarily case management with therapy as secondary activity.

Court System: Community Control Counselor is primarily a case manager and tries to get client to fulfill court ordered activities (re: counseling, restitution, etc.).

Health and Rehabilitative Services: Many HRS workers (Protective Services, Foster Care, etc.) are doing more traditionally defined case mangement activities.

CASE MANAGEMENT SYSTEM DEVELOPMENT COMMITTEE DIRECTORY

NAME: Ricky Biggins

POSITION: Coordinator, Project TOGETHER

EMPLOYED BY: Mental Health Association of Pinellas

ADDRESS/PHONE: 15733 Bedford Circle E.
Clearwater, Florida 33546

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Develop and coordinate mutual support groups for families of the mentally ill. Do case and system advocacy. Provide case management services to families as needed.

NAME: Vicki Egnew

POSITION: Department Chairman Homebound/Hospital Dept.

EMPLOYED BY: Pinellas County Schools

ADDRESS/PHONE: 1895 Gulf to Bay Blvd.
Clearwater, Florida 33515
442-1171 Ext. 260

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Placing students in homeboung/hospital program, teaching, working with homebound/hospital teachers.

CASE MANAGEMENT SYSTEM DEVELOPMENT COMMITTEE DIRECTORY

NAME: Jean Evans

POSITION: Director, Childrens Service

EMPLOYED BY: Mental Health Services of Upper Pinellas

ADDRESS/PHONE: 1437 South Belcher

Clearwater, Florida 33518

536-5950

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Manage and direct all childrens programs in the Agency - Serves as a member of management staff

NAME: Pam Flatow

POSITION: Director of Social Services

EMPLOYED BY: Medfield Center

ADDRESS/PHONE: 12891 Seminole Blvd.

Largo, Florida 33540

581-8757

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Administrative duties for Social Services Dept; Family Counseling, Intake Evaluations; Discharge Planning; Out-patient services; Individual family (primarily with children and adolescents); assist in program planning for Adolescent Unit.

CASE MANAGEMENT SYSTEM DEVELOPMENT COMMITTEE DIRECTORY

NAME: Pat Gehant

POSITION: Director of Planning

EMPLOYED BY: Pinellas/Pasco District Mental Health Board District V, Inc.

ADDRESS/PHONE: 2230 East Bay Drive
Largo, Florida 33541
585-7416

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Develop planning for Child, Adult, and Geriatric Mental Health & Alcohol Services

NAME: Susan Heavner

POSITION: Mental Health Program Specialist

EMPLOYED BY: HRS District V Alcohol/Drug Abuse and Mental Health

ADDRESS/PHONE: 2255 East Bay Drive
Clearwater, Florida 33546
536-5911 Ext. 237

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Program planning, monitoring, contracting. Chairperson of District Case Review Committee

CASE MANAGEMENT SYSTEM DEVELOPMENT COMMITTEE DIRECTORY

NAME: Glenn Kranzow

POSITION: Supervisor School Social Work

EMPLOYED BY: Pinellas County Schools

ADDRESS/PHONE: 1895 Gulf-to-Bay

Clearwater, Florida 33515

442-1171 Ext. 396

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Supervise staff of 40 Professional Social Workers - Monitor School Social Work Activities - Coordinate services within school and community

NAME: Dwight Lord

POSITION: Director of Admissions

EMPLOYED BY: Jack & Ruth Eckerd Foundation

ADDRESS/PHONE: 1350 Rogers Street

Clearwater, Florida 33516

461-2990 Ext. 52

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Act as liaison between referring agency & Foundation.

Represent the Foundation on District Case Review Committees.

CASE MANAGEMENT SYSTEM DEVELOPMENT COMMITTEE DIRECTORY

NAME: Phillip Ninios

POSITION: Supervisor Adolescent Day Treatment Center of Pasco County

EMPLOYED BY: Human Development Center, Inc.

ADDRESS/PHONE: 209 North 7th Street
Dade City, Florida 33525
(904) 521-0700

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Supervisor (Administration and Clinical) of program and staff Interface with community schools and agencies. Program design and orgainzation.

NAME:

POSITION:

EMPLOYED BY:

ADDRESS/PHONE:

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

CASE MANAGEMENT SYSTEM DEVELOPMENT COMMITTEE DIRECTORY

NAME: Donna Reynolds

POSITION: A.D.N., Maternal and Child/Mental Health

EMPLOYED BY: Morton Plant Hospital

ADDRESS/PHONE: 323 Jeffords Street

Clearwater, Florida 33516

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Responsible for nursing administration for Pediatrics, OB, Ped-Adolescent/Adult Mental Health Services.

NAME: Nick Targakis

POSITION: Social Services

EMPLOYED BY: Morton Plant Hospital

ADDRESS/PHONE: 323 Jeffords Street

Clearwater, Florida 33516

462-7132

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Placement of children after discharge from in-patient setting.

CASE MANAGEMENT SYSTEM DEVELOPMENT COMMITTEE DIRECTORY

NAME: John White

POSITION: Director

EMPLOYED BY: Mental Health Services of South Pinellas

ADDRESS/PHONE: 4040 Central Avenue
St. Petersburg, Florida 33711
327-7656

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

Director, Child Guidance Center, Out-Patient and Day Treatment Services

NAME:

POSITION:

EMPLOYED BY:

ADDRESS/PHONE:

BRIEF DESCRIPTION OF JOB RESPONSIBILITIES:

EVALUATION CONSORTIUM

The goal of improving services delivered by multiple agencies has led SED Network staff to propose the establishment of a multiagency Evaluation Consortium. It is anticipated that such a Consortium will enhance the effectiveness and broaden the ownership of the SED Network.

The Evaluation Consortium consists of five individuals representing the evaluation departments of five cooperating agencies in the SED Network: (1) Health and Rehabilitative Services, District V, (2) District Mental Health Board, V, (3) Juvenile Welfare Board, (4) District School Board of Pasco County, and (5) School Board of Pinellas County. In addition, the SED Network has contacted with Evaluation Systems Design, Inc. (ESDI) to act as an external evaluation consultant. A representative from ESDI is acting as the Evaluation Consortium team leader and coordinates evaluation activities with Network staff and Consortium members.

The Consortium is an advisory panel for SED Network staff and, throughout the funding of the Pilot Project, will serve four major evaluation functions: (1) planning evaluation procedures, (2) monitoring evaluation progress, (3) reviewing evaluation outcomes, and (4) screening SED Network dissemination plans.

Because of the broad scope of the SED Network project an evaluation plan that is geared toward documentation of activities has ben chosen. Specifically, the evaluation model developed by Stake (1979) forms the concpetual framework for SED Network evaluation plans. it is a documentation model that examines antecedents, transactions, and outcomes. The concept of documenting antecedents, transactions, and outcomes is underway. For example, descriptive data is being collected regarding the antecedents of the SED Network project, i.e., services presently existing, present level of multiagency cooperation, service accessability. Transactions are then planned to enhance antecedent conditions. The effects of these transactions are evaluated and described as project outcomes. It is anticipated that all SED Network evaluation activities will fit this evaluation plan.

Listen below are participants in the SED Network Evaluation Consortium:

Dr. Mary Ellzey, Consultant
Evaluations Systems Design Inc.
700 N. Calhoun, A-3
Tallahassee, FL 32303

Steve Iachini, Specialist
Program Evaluation
School Board of Pinellas County
1960 E. Druid Road
Clearwater, FL 33518

Wiliam M. Michaels, Director
Research and Evaluation
Juvenile Welfare Board
4140 49th Street North
St. Petersburg, FL

Robert Muzzy
Director of Evaluation
Pinellas/Pasco District Mental Health
Board V, Inc.
2230 E. Bay Drive, Suite 290
Largo, FL 33541

Michael Rapp, Director
Research and Evaluation
District School Board of
Pasco County
2609 Highway 41 North
Land 'O' Lakes, FL 33539

Dr. Lee Sherry, Project
Manager
SED Network
4960 - 78th Avenue North
Pinellas Park, FL 33564

Larry Sousa, MIS Consultant
Health and Rehabilitative
Service, District V
2255 E. Bay Drive
Clearwater, FL 33540

INFORMATION & REFERRAL GUIDE

A need identified by Pasco County school personnel during the development of the SED Network Pilot Project Proposal was the lack of a comprehensive Information and Referral Guide to services for children in Pasco County. Goal One, objective three of the 1983 SED Network proposal addresses the development of an Information & Referral system in Pasco County. Concurrently with the development of the Pilot Project, Alternative Human Services (AHS), was awarded a grant to develop an information and referral system in Pasco County. AHS has developed and maintains numerous Information & Referral manuals for many types of services in Pinellas County. They also maintain a comprehensive Hotline and Referral Network in Pinellas and Pasco Counties.

Alternative Human Services is a member of the SED Network Advisory Committee. Through mutual agreement, the SED Network and Alternative Human Services have developed a draft Information & Referral Guide to services for SED children and their families in both Pinellas and Pasco Counties.

Two editions of the Information & Referral manual are under development. One manual is designed for parents with brief listings of community and school services. The other guide is a professional guide. Doctors, social workers, psychologists and other children's workers will have a more detailed listing of services. The professional guide is more comprehensive in scope and describes programs and referral criteria. Unique to both guides is a section devoted to Exceptional Education Programs in both the Pinellas and Pasco School Districts. Descriptions of handicapping conditions, program offerings and admission/discharge criteria are contained in the guide. This type of concise, self-contained manual of special education services is the first of its type in the Pinellas/Pasco region.

The Information & Referral guides will be distributed initially by the SED Network with update flyers to users of the manuals. The production of the two guides demonstrates the multiagency cooperation and sharing of resources among two school districts and Alternative Human Services. The SED Network is proud to be the facilitator and coordinator of this effort.

SOUTH PINELLAS ADOLESCENT DAY TREATMENT PROGRAM

PHILOSOPHY

The Adolescent Day Treatment Program (ADTP) is a cooperative program intended for youth ages 12 through 17 who have been identified by the Pinellas Conty School System as Severely Emotionally Disturbed and who are unable to function adequately within the school setting because of their emotional and behavioral problems. This Program is targeted toward SED teenagers and their parents having multiple needs which cannot be exclusively met by either school-based or community mental health services.

The ADTP, therefore, is a blending of school and community mental health expertise and programs to address participant student needs in the areas of education and daily living skills, group and individual therapy, parental therapy and social service case management, health education, vocational planning socialization and recreational activities, art and music therapy and continuing post-discharge follow up. The ADTP is not to be considered a substitute, but rather a less restrictive alternative to inpatient and residential treatment programs.

It is the overall mission of this Program to implement services and an administrative system that will address these multiple needs in a manner which is timely and flexible, highly coordinated and intensive and comprehensive. The mutual commitment of full partnership among the School Board, HRS Children, Youth and Family Program office, and the Child Guidance Center will ensure the optimal development and delivery of these services to participating youth, and the eventual return of enrolled dysfunctional teenagers to their school environment.

NEEDS ASSESSMENT

The need for an Adolescent Day Treatment Program serving SED adolescents in the South Pinellas County area has been recognized and discussed among both education and mental health staff over the past year. There currently exists no such program in this area. The Juvenile Welfare Board recently promulgated a mental health residential service needs assessment that addressed the need for day treatment alternatives to expensive residential care, particularly day treatment programs that actively involved parents as potential change agents on behalf of their children.

Reaffirming this is the District Mental Health Board and Pinellas County School System with both taking the position that the need for adolscent day treatment services in District V is greatest in the South Pinellas area. With the need for this service thus established, it is the intent of this proposal to suggest an outline for a program that will address this need.

BASIC PROGRAM CONCEPTS

In order to achieve this mission, basic assumptions about the needs of the students to be served, and the Program being developed to meet these needs, must be described.

First, the participant student's potential for positive change is significantly influenced by parental involvement. Therefore, optimal Program benefit will be achieved by those parents who participate during the admission, service delivery, and follow-up phase of the Program. Secondly, the students to be served will, by definition, have a multiplicity of problems and needs requiring an individualized and coordinated plan of educational programming and mental health service delivery. This applies to both the students and their family members.

To accomplish this will require an intensive, flexible and comprehensive program for each student. Education, therapy and related activities must be relevant and pragmatic in their approach to enhance personal growth and develop skills in interpersonal relationships as well as forward and consistent over a time, to establish a predictable milieu predicated on trust. Student progress will be by increasing opportunities for flexibility in Program structure and self-directed activity. The ADTP must emphasize positive aspects fo functioning in a manner which fosters student independence and the resulting personal sense of responsibility.

PROGRAM OVERVIEW

The ADTP will be provided to teens of both sexes, ages 12 through 17, at the Enoch Davis Community Center located at 18th Avenue and 11th Street South in St. Petersburg. This Center is a modern, multi-purpose community facility managed by the City of St. Petersburg and recognized as a soruce of social and municipal services for residents of the surrounding community. Adolescents will be referred to the Program by the Pinellas County School System or community providers. Educational specialists and mental health clinicians will participate in screening and evaluating the applicants, whereupon their combined recommendations will be presented to the Department of Education for Exceptional Student Screening Committee which determines eligibility. The ADTP will accommodate up to eight Severely Emotionally Disturbed teenagers per day. Once enrolled, students will participate five days per week during the regular school year schedule.

The ADTP will be staffed by a Supervisory Master's Degree level Mental Health Professional, an SED Teacher (school-based employee), a Classroom based Mental Health Technician, a Professional level Mental Health Family Therapist, and a Consultanting Psychiatrist. These individuals, plus School and Mental Health Administrators will function as a closely-knit team pertinent to the mission of holistic intervention with students and their families. The length of stay in the Program will depend on individual student attainment of the combined ITEP objectives. Upon reaching these benchmarks, the student will be mainstreamed into an

appropriate educational setting. It is intended that students will remain in the Program no longer than is necessary to meet ITEP objectives, with the knowledge that less restrictive educational resources, in addition to mental health outpatient counseling and follow-up case management services, will continue to be provided to students and family members upon discharge from the Program, as long as these services are required.

In addition to overall Program coordination, the on-site Mental Health Professional Supervisory Staff will perform individual, group and activity therapy for participating youth. This will be accomplished in close cooperation with those classroom learning and daily living skills activities performed by the Teacher and the Mental Health Technician. Classroom-based Teaching and Mental Helath staff will offer academic instruction, plus socialization, vocational planning, recreational and daily living skills training on both a didactic and on an experiential level. These staff will work in unison to establish and maintain a structured, consistent therapeutic milieu in the classroom that will minimize opportunities for negative interactions and provide an atmosphere conducive to learning and personal growth. The additional Mental Health Therapist will be responsible for the provision of family evaluations, individual and couple therapy for parents, social service case management, and parent group meetings in coordination wih other Program staff. Consultant Psychiatric and staff psychological services will be available to both the students and family members where there is a need for this level of intervention. Finally, the ADTP will comply with all applicable Department of Education and HRS Florida Statutes and Florida Administrative Codes.

SUPPORT SERVICES

During the first semester of operation, the students will utilize the Municipal Bus System or privately arranged transportation for conveyance to and from the Program. Public School transportation will be explored for the 1984-85 school year. Lunches for the students will be provided by a neighboring school, and transported to the Enoch Davis Center for consumption.

Clerical support services will be provided by existing Child Guidance Center staff based at the 3820 Central Avenue facility. They will offer telephone reception through a direct line to the Program. Additionally, existing Child Guidance Center support staff will provide transcription and related office management services to the Program.

IMPLEMENTATION TIMETABLE

Physical space for the ADTP will be leased from the City of St. Petersburg in early December, 1983. The staff will be recruited during December to begin in early January. Contracts with HRS Children, Youth and Family Program office and the Pinellas County School Board, will be finalized in December. The first advance for start-up expenses will be requested at the time the contract with CYF is consumated.

Program staff will receive orientation in early January. They will participate in equipping and setting-up the facility, and in drafting key policies and procedures, relevant to such matters as intake, client eligibility, client records, parental involvement, decision-making, substitute staff, confidentiality, food, transportation, medication, crisis intervention, etc. It is anticipated that major policies and procedures will be in place by the end of January. Telephone installation and school lunch arrangements will also be finalized during this time. Therefore, it is projected that the ADTP will be in full operation by the beginning of February, 1984.

ADOLSCENT DAY TREATMENT PROGRAM GOALS

1. To provide individualized academic instruction of the participant adolescents that will earn course credits applicable toward meeting requirements for high school graduation.

2. To provide a classroom milieu conducive to academic learning, positive interpersonal relationships, the acquisition of daily living skills, and socialization and recreation skills.

3. To provide individual and group therapy addressing both affective and behavioral problems of enrolled teens, that are manifested both at home and in the classroom setting.

4. To provide family evaluations, therapies, social services and supportive parent group activities, both in the parental home and at the Program site.

5. To provide psychiatric services and psychological evaluations for students and parents requiring this level of care.

6. To provide an integrated educational/mental health team approach to address the multiple needs of participant youth and their families.

7. To provide social service case management to ensure needed community-based health and social services in addition to the educational and mental health programs offered at the Center.

8. To provide an array of pragmatic daily living skills activities utilizing both Program and community-based resources.

9. To provide social and recreational activities designed to enhance adolescent interpersonal skills.

10. To provide adequate administrative support services commensurate with Program objectives.

11. To recruit and engage community-based volunteers who will assist the Program, especially in the provision of daily living skills activities, and social and recreational events.

12. Upon attainment of educational/mental health ITEP objectives, to provide a timely discharge to the least restrictive educational/mental health setting appropriate to the needs of the student.

13. To provide appropriate follow-up services to both the teen and his family after discharge from the Program. This would include provision of continued outpatient therapy as may be required.

14. To conform with applicable Department of Education and Health and Rehabilitative Services Statutes and Administrative Codes as well as the Pinellas County School System Code for Student Conduct.

GENERAL ADMISSION CRITERIA

Severely Emotionally Handicapped adolescents, ages 12 through 17, will be considered for admission to the ADTP where they meet the following criteria:

1. Applicant youth may be referred through the Pinellas County School System or by other community agencies.

2. Youth to be considered for placement will have the potential to be identified as Severely Emotionally Disturbed by the Pinellas County School System through the DEES Screening Procedure, and may have previously been the recipient of School SED services. Generally, these are adolscents with a history of unsuccessful functioning in the School's Exceptional Child Education Program.

3. Youth to be considered for the ADTP will require specialized educational programs for the full school week.

4. Adolescents to be considered will have multiple problems in both educational and mental health related areas of their functioning.

5. Program candidates will have dcmonstrated a high frequency of behavioral problems and non-acceptance of social mores and standards of conduct. Involvement with the Juvenile Justice System will not disqualify an applicant for admission to this Program.

6. Applicants whose parents are motivated to participate in the Program, and who are a source of current influence with their teenaged children, will be regarded as optimal candidates for the Program.

7. Adolescent candidates for this Program will generally have experienced pervasive problems in maintaining interpersonal relationships and will have known a lack of success in school and work-related situations.

8. No youth will be denied admission to the ADTP on the basis of race, sex, religious affiliation, or national origin. There are no fees charged to the youth or his family in connection wth ADTP services.

SPECIFIC ELIGIBILITY CRITERIA

1. Applicants will be between the ages of 12 and 17.

2. Applicants will not have a history of mental retardation, organic brain dysfunction, severe learning disability, or unmanageable physical anomalies.

3. Applicants will have been determined SED eligible by the DEES Screening Committee.

4. Parents or guradians of applicant students must be cooperative with Program objectives, and formally agree to participate in treatment to the extent outlined in the ITEP, at a minimum of two treatment activities per month. The ITEP will address problems occurring both in school and in the home setting.

5. The applicant and his family must be capable of making transportation arrangements for conveyance to and from the Program. Staff is available to offer assistance in this planning.

6. Selection of applicants will be based upon establishing and maintaining a heterogenous Program population, in the interest of both facilitating student progress and in maintaining Program management. In this regard, no more than two students with histories of severely disruptive classroom behavior will be served in the Program at any one time.

7. It should be reasonably anticipated that there will be no change in the student's living arrangement with either his family or his guardian during his stay in the Program.

8. Applicant students for the ADTP must have the capability of abiding by provisions of the Pinellas County Public School Student Code of Conduct applicable to exceptional student programs.

COMMUNITY INVOLVEMENT

It is the goal of the ADTP to gain community acceptance and participation in terms of the needs presented by both the Program clients and their families. The family therapist staff will assume a lead role in the performance of intensive case management services for families of the students in the Program. The staff will negotiate, arrange, and coordinate an array of community services and resources, including entitlement, vocational, rehabilitative, health and other human services required by the family. In this process, staff will endeavor to educate community teachers, pastors, and other caregivers about mental health needs of children and adolscents in South St. Petersburg. This will be accomplished through consultation activities and service on community boards and advisory groups. The staff will look to the local community to share in the development of job placements, and socialization and recreation resources needed by youth and family members enrolled in the Program. Clinical consultation services may be exchanged for the provision of these services to youth in the Program. Finally, the Enoch Davis Center is the nucleus of local community activity, and as such, will be utilized by staff as a vehicle to enhance inter-agency coordination and sharing of service provision for Program participants.

BUDGET NARRATIVE

MHSSP has projected a low start-up budget for the ADTP with the expectation of soliciting equipment from community resources, as well as using materials currently on hand at the Mental Health Center and equipment available from the Public School System. Specifically, the storage cabinet is needed for Program supplies. The folding tables, card tables, and stack chairs are the basic furnishings for the various Program activities. The six additional stack chairs will furnish staff offices for therapy purposes. Lunches will be brought in from a nearby public school, limiting the need for kitchen equipment to a refrigerator and hot-plate to preserve and heat incidental food items.

In explanation of Program Supplies, monies budgeted for recreational, art, craft and music supplies pertains to activity and therapy material to be expended by the adolescent clients in the non-classroom aspects of the Day Program. The Insurance item includes comprehensive professional, as well as physical and property liability which covers the Mental Health staff and the facility. Travel Funds are needed in support of professional staff, home visits, community consultation and development activities, and related patient case management work. The Fuel/Oils and Van Maintenance items pertain to the operation and upkeep of the Program's part-time use of a venicle currently owned by MHSSP. The van will be used for field trips, lunch pick-ups and related patient conveyance. The Rent item is for 2,392 square feet of Program space at $6.50 per square foot on an annualized basis. Rental includes all utilities except telephone, as well as internal and external maintenance and the use of Enoch Davis Center common areas. Finally, the cost reflected for telephone service includes installation, plus the monthly service charge for two telephones serving the Program. The ADTP telephones will tie in with the Child Guidance Outpatient switchboard, thereby eliminating the expense of a receptionist at the Program location.

Finally, the budget for Staff Expenses includes an experienced, Master's Degree level Clinical Program Supervisor who will be responsible for other Mental Health staff and for day-to-day Program operation. The second Mental Health Professional will be a Master's Degree level Family Therapist, with minimal work experience, who will perform the treatment and intensive case management services to clients and their families.

Lastly, the Bachelor's Degree level Mental Health Paraprofessional will be stationed in the classroom and will be responsible for the therapeutic milieu and group activities with the participating youth. Additionally, $1,170 will be expended to fund 52 hours of contract psychiatric time for Program participants at the rate of $45 per hour.

Fringe Benefit costs are calculated at the following rates:

FICA - 7%
Medical Insurance at $90 for three staff over a period of six months.

Retirement at the rate of 10% on $9,163 of salary (only one staff will be eligible for retirement benefits during the initial contract period).

Workers Compensation at $2.90 per $1,000 of payroll, and Unemployment Compensation at 1.03% of the Program payroll.

In summary, 71% of the Total Program Budget is reflected in Staff Costs, while 4% has been allocated to Start-up and 25% to Operating Expenses.

MENTAL HEALTH SERVICES OF SOUTH PINELLAS, INC.
ADOLESCENT DAY TREATMENT PROGRAM

Start-up

1	Storage cabinet		$ 179.
2	7' Folding Tables	@ $98. each	196.
2	Card Tables	@ 35. each	70.
12	Folding Stack Chairs	@ 55. each	660.
6	Side Chairs	@ 55. each	330.
1	Refrigerator (used)		250.
1	2-Burner Hot Plate		35.
		Total	$1,761.

Operating Expenses	Annual	6 Months
Recreational Supplies	$ 500.	$ 250.
Arts/Crafts/Music	250.	125.
Postage	150.	75.
Insurance	750.	375.
Office Supplies	300.	150.
Travel	500.	250.
Fuel and Oils	180.	90.
Van Maintenance	320.	160.
Rent	15,548.	7,774.
Phone Installation and 6 Months Service Charge		604.
	Total	$9,854.

Staff Costs

1	Mental Health Professional I	$14,360.	$ 7,180.
1	Mental Health Professional I	18,327.	9,163.
1	Mental Health Technician II	12,847.	6,424.
	Fringes for above		4,448.
		Total	$27,215.
Psychiatrist 52 hrs. at $45. = $2,340.			1,170.
		Total Staff =	28,385.
		Total Start-up =	1,761.
		Total Operating Expenses =	9,854.
		Total Program =	$40,000.

MENTAL HEALTH SERVICES OF SOUTH PINELLAS, INC.

JOB DESCRIPTION

Position # 032

MHSSP Job Title Mental Health Technician II

State Job Classification and Code Clinical Social Worker I - 4121

Major Program Assignment Adolescent Day Treatment

Immediate Supervisor Coordinator of Adolescent Day Treatment Services

Person Filling Position Refer to Position Control Log

State Pay Grade 14 MHSSP VIII

DISTINGUISHING CHARACTERISTICS OF WORK

This is full-functioning, paraprofessional clinical work in support of the professional staff of a comprehensive community mental health program. Work involves implementing certain treatment regimens for mental health clients.

Work is performed in accordance with established policies and procedures, and is either under direct supervision of professional staff who have developed the treatment goals and objectives, or is performed where professional assistance and guidance are available upon request. Employees are expected to make independent clinical judgements, within well-defined parameters, when making decisions as appropriate treatment alternatives for the client. However, unusual behaviors and occurrences are immediately reported to high-level, professional staff or psychiatric consultation is obtained. Employees in this class exercise no supervision. Employees receive direct supervision from the supervisor of the area assigned. Work is reviewed primarily by direct observation and by review of initial evaluation reports, case reports, progress notes and charts, and through individual discussion and counseling.

JOB DUTIES

Plans, implements and leads Adolescent Day Treatment patient group activities and events. Performs individual and group supportive counseling for Adolescent Day Treatment patients where indicated. Manages and coordinates delivery of required mental health services for assigned Adolescent Day Treatment patients. Prepares clinical summaries and reports. Consults with other care providers to give and receive patient information, and to plan case management strategies.

Maintains and processes patient activity logs. Makes clinical notations in patient charts.

Participates in staff meetings, supervisory conferences, staff development activities, and committee work.

Performs other related duties as required.

MINIMIM REQUIREMENTS OF EDUCATION AND EXPERIENCE

Either graduation from an accredited four-year college or university, preferably with major course work in one of the social sciences. Or graduation from a standard senior high school, preferably supplemented by college-level course work in the social sciences, and two years of increasingly responsible experience in a child or adolescent community mental health program at the level of a Mental Health Technician I or above.

DESIRABLE SPECIAL QUALIFICATION

Successful completion of an advanced first aid course sponsored by the American Red Cross or similar organization or licensure by the State of Florida as a Practical Nurse.

Valid Florida driver's license and availability of an automobile.

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MENTAL HEALTH SERVICES OF SOUTH PINELLAS, INC.

JOB DESCRIPTION

Position # 033

MHSSP Job Title Coordinator of Adoescent Day Treatment Services

State Job Classification and Code Clinical Social Services Director - 4127

Major Program Assignment Adolescent Day Treatment

Immediate Supervisor Director of Children's Services

Person Filling Position Refer to Position Control Log

State Pay Grade 19 MHSSP XIII

DISTINGUISHING CHARACTERISTICS OF WORK

This is responsible work in directing a clinical mental health program for adolescents.

An employee in a position allocated to this class is responsible for planning, organizing and directing the day-to-day activities of an adolescent day treatment program. Work involves implementing through subordinate clinical staff the therapy program and activities designed to facilitate the program; consulting and participating in staff development, and in-service training programs.

Supervision is received from an administrative superior and work is accomplished with some independence within the framework of the Center's policies and procedures.

EXAMPLES OF WORK PERFORMED

(NOTE: These examples are intended only as illustrations of the various types of work performed in positions allocated to this class. The omission of specific statements of duties does not exclude them from the position if the work is similar, related, or a logical assignment to the position.)

Assists in developing and implementing an adolescent day treatment program.

Supervises subordinate mental health professional and technician staff in the program.

Assists in developing program policies and procedures to ensure compliance with Agency directives.

Coordinates the development and training aspects of the adolescent day treatment therapy programs for the professional and non-professional staff.

Provides staff supervision for all program clients.

Performs related work as required.

MINIMUM TRAINING AND EXPERIENCE

A Master's Degree in a social or rehabilitative science and three years of mental health experience relevant to adolescents, preferably one of which has been in a supervisory capacity.

Valid Florida Driver's Licencse.

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MENTAL HEALTH SERVICES OF SOUTH PINELLAS, INC.

JOB DESCRIPTION

Position # 034

MHSSP Job Title Mental Health Professional I

State Job Classification and Code Clinical Social Worker II - 4122

Major Program Assignment Adolescent Day Treatment Services

Immediate Supervisor Coordinator of Adolescent Day Treatment Services

Person Filling Position Refer to Position Control Log

State Pay Grade 16 MHSSP X

DISTINGUISHING CHARACTERISTICS OF WORK

This is responsible clinical social work providing guidance and counseling to the families and patients of an adolescent day treatment program.

An employee in a position allocated to this class is responsible for conducting individual and group guidance and counseling sessions to the program. Duties include counseling adolescents with adjustment problems, working with the families of the patients in order that they may understand and assist in the counseling, and providing interim case management services for both participant youth and their families.

Supervision is normally received from a higher level technical employee and is reviewed for the desired results.

EXAMPLES OF WORK PERFORMED

(NOTE: These examples are intended only as illustrations of the various types of work performed in positions allocated to this class. The omission of specific statements of duties does not exclude them from the position if the work is similar, related, or a logical assignment to the position.)

Provides counseling and guidance for parents of youth in the program.

Provides counseling and guidance services to adolescent day treatment patients.

Counsels families and guardians of patients in adjustment problems.

Participates in team diagnostic and technical staff conferences.

Prepares case histories, reports and maintains records.

Performs related work as required.

MINIMIM TRAINING AND EXPERIENCE

Graduation from an accredited four-year college or university and a Master's Degree in psychology, social work, or related mental health discipline. Two years of mental health or guidance counseling experience with children or adolescents is preferred.

NECESSARY SPECIAL REQUIREMENTS:

Valid Florida Driver's License.

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SED DEFINITION COMMITTEE

INTRODUCTION

The State SED Advisory Committee, during the October, 1983 meeting, suggested that the most appropriate group of professionals knowledgeable in the issue of criteria defining a severely emotionally disturbed (SED) child is the local District Case Review Committee (CRC). This is a meritorious suggestion since the CRC's are constantly redefining criteria for hospital and residential placements of SED children and youth. Although many cases have similar etiology and thus similar needs, each case is considered individually. The individualization of case review requires constant reinterpretation of eligibility criteria as each case is considered. The need for a consistent, widely accepted definition of the SED child/youth grows as the number of cases referred to the CRC increase.

The dichotomy between education and mental health definitions of severity of emotional disturbance continues to hamper smooth service delivery between school and community service provider agencies. A comprehensive definition encompassing both education and mental health viewpoints may draw the two systems closer together.

The SED Network is actively involved with community service providers in developing a Case Management System for SED children and youth. The need for a convenient definition of SED has become even more apparent as issues associated with Case Management are explored.

Common language promotes better understanding and enhances communication among professionals. At present, there exists no common language defining the severity of emotional handicaps. The SED Network is expediting and facilitating the development of an acceptable definition of the SED category.

Benefiting from the State SED Advisory Committee's suggestion, the members of the HRS District V Case Review Committee (CRC) are being called upon to review existing definitions of SED and participate in the development of a new and common definition. In an effort to make this task as efficient as possible, SED Network staff have begun a literature review of recent research in the area of SED. Based on a brief review of the literature, a concept paper outlining the most common definitions of SED has been prepared. The paper investigates both the Clinical as well as the Educational definition of SED. The paper, concludes by suggesting ten (10) issues that CRC members will need to consider in developing an appropriate definition.

The HRS District V CRC meets at least once each month. Regularly scheduled at the beginning of each monthly meeting is a work session. The members discuss, develop and review material pertinent to a new definition of SED. The committee members have approached this task with enthusiasm. They have accepted the challenge and anticipate creating a definition that may be of benefit to other District Case Review Committees.

Attached is the concept paper developed by SED Network staff for CRC review and discussion. From this beginning it is anticipated that the new definition of severely emotionally disturbed will evolve.

SED DEFINITION COMMITTEE

Current Definitions

The following two definitions are those applied to children considered to be seriously emotionally handicapped. They are drawn from two nationally recognized sources. In the field of Mental Health, the Diagnostic and Statistical Manual of Mental Disorders-III serves as the standard for diagnosis of emotional and behavioral dysfunctioning. In Education, Public Law 94-142, the Education of All Handicapped Children Act, offers a descriptive definition of the seriously emotionally handicapped child. By federal mandate, local public schools adopted the Public Law 94-142 definition. An examination of Florida school districts has shown that all District Procedure manuals list similar definitions.

The SED Network Definition Committee task will not be easy, but will certainly be challenging. Burns, et al. (1981) conclude:

> "Two characteristics of childhood, rapid development and growth, and children's dependent and reactive relationship with their environment - indicate that children cannot simply be classified using diagnostic terms developed for adults. However, constructing an appropriate system for children is not a simple matter. The disagreement among child mental health specialists about the best approach to classifying mental disorders for their own use illustrates the difficulty in applying general principles about children to a classification system; this disagreement reflects the relative lack of research into childhood problems and the resulting lack of an adequate conceptual framework for understanding and treating them."

Through a combined effort the Committee may be able to combine the clinical and educational definitions of Severely Emotionally Disturbed.

<u>Clinical Definition</u>

DSM-III: "....each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is limited to a conflict between an individual and society, this may represent social deviance,...but is not by itself a mental disorder.)"

In addition, the DSM-III addresses other issues related to the definition of emotional disorders.

> "In DSM-III there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, as well as between it and no mental disorder. For example, there has been a continuing controversy as to whether or not severe depressive disorder and mild depressive disorder differ from each other qualitatively (discontinuity between diagnostic entities) or quantitatively (a difference on a severity continuum). The inclusion of Major Depression With and Without Melancholia as separate categories in DSM-III is justified by the clinical usefulness of the controversy as to whether or not these conditions are in fact quantitatively or qualitatively different."
>
> A common misconception is that a classification of mental disorders classifies individuals, when actually what are being classified are disorders that individuals have. For this reason, the text of DSM-III avoids the use of such phrases as "a schizophrenic" or "an alcoholic," and instead uses the more accurate, but admittedly more wordy "an individual with Schizophrenia" or "an individual with Alcohol Dependence."
>
> Another misconception is that all individuals described as having the same mental disorder are alike in all important ways. Although all the individuals described as having the same mental disorder show at least the defining features of the disorder, they may well differ in other important ways that may affect clinical management and outcome."

The Committee will need to consider quantitative and qualitative concerns in conceptualizing the SED definition. The misconception suggested by DSM-III that "all individuals described as having the same mental disorder are alike in all important ways..."will also need to be explored.

The DSM-III also suggests that a difference exists between definitions that rely on etiology as opposed to those that merely describe the apparent disorder.

> "Because DSM-III is generally atheoretical with regard to etiology, it attempts to describe comprehensively what the manifestations of the mental disorders are and only rarely attempts to account for how the disturbances come about, unless the mechanism is concluded in the definition of the disorder. This approach can be said to be "descriptive" in that the definitions of the disorders generally consist of the clinical features of the disorders. These features are described at the lowest order of inference necessary to describe the characteristic features of the disorder. Frequently, the order of inference is relatively low, and the characteristic features consist of easily identifiable behavioral signs or symptoms, such as disorientation, mood disturbance, or psychomotor agitation."

Descriptive definitions are low inference types since the clinician making the diagnosis does not have to make 'clinical' or intuitive evaluations of how the disorder may have developed. Perhaps the committee will focus on more behavioral or descriptive definitions to avoid the pitfalls of over extending the diagnosis with high inference statements. Clearly an operational behavioral description will need to be included in the definition. As noted, some definitions of emotional disorders benefit from etiological analysis. Onset and duration are keys to diagnosis and prognosis. These issues will also need to be addressed by the committee.

Educational Definitions

Public Law 94-142 was signed into Federal Law in 1975. Since then it has made a significant impact on public educators. The mandates of the law require that the public schools provide a free, appropriate education for all children, without regard for the handicapping condition. The law defines each category of exceptional child and serves as a guideline for all state and local education agencies.

Public Law 94-142 defines seriously emotionally disturbed as follows (Federal Register, August 23, 1977):

> (i) "The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
> (A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
> (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
> (C) Inappropriate types of behavior or feelings under normal circumstances;
> (D) A general pervasive mood of unhappiness or depression, or
> (E) A tendency to develop physical symptoms or fears associated with personal or school problems;
> (ii) The term includes children who are schizophrenic or autistic. The term does not include children who are socially malajusted, unless it is determined that they are seriously emotionally disturbed."

The definition consists of four major components:

(1) Alternate Placement "after receiving supportive services... available to all students"
(2) Behavioral Deviation "persistent and consistent severe... behavioral disabilities"
(3) Behavioral Interference "interference with productive learning process"
(4) Exclusion Clause "cannot be attributed primarily to physical, sensory or intellectual deficits."

These components are related to "success in school" as the criteria of normality. A severe emotional disorder precludes this success.

The dichotomy of definitions (e.g., clinical vs. educational) may be explained by the orientation of the Public Law 94-142 definition to focus on school success. School success is not always objectively measured. The clinically defined SED child may function acceptably in a school setting long enough to avoid labeling, yet still have a severe emotional disorder at home.

The District School Board of Pasco County and the School Board of Pinellas County have adopted the federal/state definition. Both school districts are guided by the following definition as stated in their respective District Procedures Manual:

(1) The emotionally handicapped (EH) student is one who, after receiving supportive educational assistance and counseling services available to all students, still exhibits persistent and consistent behavioral disabilities which consequently disrupt the student's own learning process. This is the student whose inability to achieve adequate academic progress or satisfactory interpersonal relations cannot be attributed primarily to physical handicaps, sensory deficits, or mental retardation. The term does not include students who are socially maladjusted.

(2) The severely emotionally disturbed (SED) student is defined as one who meets the criteria as defined in the definitions above and who requires a special center program for the full school week, and who requires extensive supportive services. Emotionally handicapped students placed in a special center class are considered severely emotionally disturbed and are described as:

- Those students who cannot function successfully in a regular school setting with supportive assistance and intervention.
- Those students with a high frequency of behavioral problems.
- Those students who may be unaware of normal codes of conduct.
- Those students who exhibit an inadequate ability to establish and maintain adequate social relationships.

(3) Eligibility criteria for programs for severely emotionally disturbed include, in addition to the criteria listed above, the following eligibility requirements for severely emotionally disturbed placement:

(a) Evidence that the student requires a program for the full school week which provides a highly structured cognitive and affective curriculum, individual or group counseling, and parent counseling or education; and

(b) Evidence that a program in the less restrictive environment has not met the individual student's needs.

In this definition, mention of the socially maladjusted student is made. At the present time, the socially maladjusted child is not considered to have a severe emotional disorder and is usually served in an "alternative school" program. Recently research has been conducted by the Council of Administrators of Special Education (CASE) (1983) that suggests that the socially maladjusted child should be included under the SED definition and be classified as an "exceptional student."

The final recommendations of the CASE study suggest:

> The criteria and procedures most often used in local settings for identifying children who are seriously emotionally disturbed appear appropriate responses to the current federal definition; but current belief would support revision of that definition. Such revision might include (1) elimination of the need for differentiation between "seriously emotionally disturbed" and "socially maladjusted" and (2) incorporation of child evaluation based upon behavior observed and described within the framework of a full description of the environment and conditions in which the behavior occurs.

The study examined many state's definitions and program offerings for both Socially Maladjusted and Severely Emotionally Disturbed. The report concluded that there is little difference in program type or curricular offerings for either category of child. This issue may be kept in mind by the committee, but initially may not be of major importance. The second recommendation refers to "behavior observed and described." This approach is consistent with the DSM-III suggestion to identify behavior patterns as opposed to etiology.

During the 1979-80 school year, the Pinellas County School's for Emotionally Handicapped established a multidisciplinary Task Force. This Task Force explored the program needs of EH children to guarantee quality service. The group recommended specific behavioral criteria be used for the identification of children/youth place in special center programs. Listed below are the 21 criteria recommended:

1. Is unable to function in regular class school
2. Can respond to primary reinforcement
3. Has poor work habits
4. Has poor or no interpersonal relationships
5. Needs constant structure
6. Needs constant supervision
7. Does not respond well to authority figures
8. Has poor self-control
9. Needs a great deal of direction to follow class routine
10. Disrupts class activities
11. Is unable to delay gratification
12. Is unable to remain on task
13. Has few self-help skills
14. Is unable to deal with stress
15. Cannot accept responsibility for own behavior
16. Is unable to cope with frustration
17. Is unaware of appropriate behavioral alternatives
18. Has no respect for property
19. Is rejected by peers
20. May be destructive to self and others
21. May have a medical diagnosis such as schizophrenic.

Almost any child may display one or more of these behaviors. It is the frequency, duration and intensity of the behaviors that differentiate the normal from the severely emotionally disturbed child.

SED Definition Committee Tasks

Listed below are ten issues that the Committee will need to consider as it completes its task. All of these issues have prevented the development of a comprehensive definition. The controversy goes beyond the boundaries of HRS District V; it is a state and national concern.

1. A consistent accepted definition of SED will be difficult to produce.
2. Clinical verses Educational Philosophies should be explored and possibly reconciled.
3. Behavioral definitions or descriptions should be considered.
4. Etiological definitions are probably not best, but should be included in the overall definition.
5. Duration, onset, severity of inappropriate behaviors or dysfunctions should be considered.
6. Globalness of dysfunction (i.e., sick at home, not at school) should be explored.
7. Implications of a new definition on program development or treatment modalities will need to be discussed.
8. Will a more general definition of SED effect the Case Review Committee's functioning?
9. Who should diagnose? School, Mental Health, Psychiatrist.
10. Once a general definition of SED has been developed, who should push for state acceptance? Should regulations be changed?

GOAL 1	PROVISION OF A COMPLETE ARRAY OF EDUCATION, MENTAL HEALTH TREATMENT AND RESIDENTIAL SERVICES.
	OBJECTIVE 1.0: To verify the current status of services in the Pasco/ Pinellas Region as they interface the Juvenile Courts.
	1.1 Verify services provided by the Juvenile Justice System, HRS and others.
	1.2 Develop entry and exit procedures for delinquent SED students.
	1.3 Identify barriers/constraints and develop guidelines for service.
	1.4 Develop a computer-based data bank that identifies services.
	OBJECTIVE 2.0: To expand community awareness of services available to SED students and their families.
	2.1 Use existing community awareness activities.
	2.2 Organize information on efficient referral of services.
	2.3 Develop a system to disseminate information to community groups.
	2.4 Update materials for use in development of community awareness.
	2.5 Make presentations to professional organizations.
	2.6 Work with news media to disseminate information.
	OBJECTIVE 3.0: To identify additional direct service gaps in the Pasco/ Pinellas region.
	3.1 Continue to analyze data from local needs assessments.
	3.2 Participation in JWB needs assessment.
	3.3 Prioritize service needs and assist in acquiring resources.
	3.4 SED Network will respond to recommendation of 1983 JWB Residential Report.
	3.5 Examine feasibility of a Day Treatment Program in South Pinellas County.
	OBJECTIVE 4: To expand the availability of Adolescent Treatment Programs in Pasco and Pinellas Counties.
	4.1 Provide seed money for Mental Health Specialist I in Pasco County.

GOAL 2	IMPROVEMENT OF EXISTING EDUCATION, MENTAL HEALTH TREATMENT, AND RESIDENTIAL SERVICES.
	OBJECTIVE 1.0: To evaluate the ITEP developed by professionals in Pinellas and Pasco Counties.
	1.1 Evaluate data collected on the ITEP.
	1.2 Modifications will be solicited and evaluated.
	1.3 Modifications as suggested will be distributed for approval.
	1.4 The approved ITEP will be introduced to selected SED staff.
	1.5 ITEP will be piloted and data collected.
	OBJECTIVE 2.0: To evaluate the use of the Developmental Hierarchies of Behavioral Objectives in ADT programs.
	2.1 Evaluate behavioral data collected.
	2.2 Develop a Handbook of Educational and Behavioral Objectives.
	2.3 Introduce use of Handbook in ADT programs.
	OBJECTIVE 3.0: To develop observation instruments to collect behavioral data as defined by the ITEP.
	3.1 Evaluate Behavioral and Academic objectives.
	3.2 Design observation instruments for SED.
	3.3 Field test developed instruments and collect data.
	3.4 Review observation instruments and prepare for use.
	OBJECTIVE 4.0: To expand the availability of vocational prorams to SED students in the Pinellas/Pasco region.
	4.1 Investigate potential career educational/vocational training.
	4.2 Determine appropriate career/vocational education program options.
	4.3 List issues to preventing SED students from receiving services.
	4.4 Recommendations will be reviewed and offered to professionals.
	OBJECTIVE 5.0: To expand residential treatment placement options available.
	5.1 Assist in coordinating planning and funding of local agencies.
	5.2 Classify potential educational and therapeutic options.
	5.3 Develop/coordinate multiagency training components.
	5.4 Provide data to Pasco County on program options.
	OBJECTIVE 6.0: To expand alternatives to residential treatment placement options in Pasco/Pinellas.
	6.1 Assist in coordinating planning of a non-residential program.
	6.2 Classify potential obtions available to students in Day Treatment.
	6.3 Develop/coordinate multiagency training components.
	6.4 Provide data to Pasco County direct service providers.
	OBJECTIVE 7.0: Establish policies and procedures for school-based "alternative to suspension" program in Pinellas County.
	7.1 Examine other community's "alternative to suspension" programs.
	7.2 Compile best procedure information.
	7.3 Plan and pilot alternative program in Pinellas County.
	7.4 Disseminate policies and procedures established by pilot project.

GOAL 2	IMPROVEMENT OF EXISTING EDUCATION, MENTAL HEALTH TREATMENT, AND RESIDENTIAL SERVICES.
	OBJECTIVE 8.0: To improve therapeutic approaches and techniques used in the school-based SED programs in Pinellas/Pasco Counties.
	8.1 Conduct a comprehensive literature review.
	8.2 Analyze data collected during Phase I (1983).
	8.3 Develop a presentation to introduce the use of video activities.
	8.4 Develop Video Tape Activity Training Module.
	8.5 Develop video tapes of sample activities.
	8.6 Conduct training workshops and provide technical assistance.
	OBJECTIVE 9.0: To improve school and hospital intake procedures for students entering and leaving hospital programs.
	9.1 Gather information and discuss issues.
	9.2 Develop new procedures.
	9.3 Report new procedures.
	9.4 Submit new procedures for review.
	9.5 Serve as consultants for implementation of the procedures.
	OBJECTIVE 10.0: Improve teacher/mental health technician effectiveness through staff development
	10.1 Inservice training programs to infuse therapeutic techniques.
	10.2 Increase staff development time and combine Pinellas/Pasco staffs.
	10.3 Implement staff development for SED present staff.
	10.4 Implement staff development for new SED staff.
	OBJECTIVE 11.0: To expand Adolescent Day Treatment options within District V.
	11.1 Coordinate planning for new adolescent day treatment program.
	11.2 Document multiagency planning process.

GOAL 3	CONTINUOUS PLANNING, IMPLEMENTATION, EVALUATION OF EDUCATION, MENTAL HEALTH AND RESIDENTIAL SERVICES.
	OBJECTIVE 1.0: To improve communication of existing committees involved in planning, funding, and evaluation.
	1.1 Review existing policies, procedures and regulations.
	1.2 Disseminate information to DMHB V and other agencies.
	OBJECTIVE 2.0: Verify the definition and placement criteria for SED students.
	2.1 Monitor all SED placements in school and community-based services.
	2.2 Submit report to Advisory Committee on characteristics of SED students.
	2.3 Submit report to HRS and DOE with definition of SED student.
	2.4 Disseminate technical assistance report to other Networks.
	OBJECTIVE 3.0: Maintain function of the Advisory Committee.
	3.1 Recruit new members.
	3.2 Hold election of new chairperson.
	3.3 Review process for making decisions and consensus.
	3.4 Select new meeting times and locations.
	3.5 Determine necessary sub-committees or task forces.
	3.6 Update list of issues to explore.
	OBJECTIVE 4.0: Develop strategies to enhance interagency cooperation.
	4.1 Evaluate data collected from SED teachers/mental health staffs.
	4.2 Develop and present technical assistance reports.
	4.3 Forward recommendations to policy developers in state DOE/DHRS.
	4.4 Project's State Consultant will respond to recommendations.
	OBJECTIVE 5.0: Identify present use of computers for data management system.
	5.1 Survey agencies on Advisory Committee.
	5.2 Prepare report on service providers computer capabilities.
	5.3 Distribution of document to Advisory Committee.
	5.4 Advisory Committee will explore linkage of hardware systems.
	OBJECTIVE 6.0: Develop a Linkage System with existing Case Management System.
	6.1 Review commonalities in Case Management practices.
	6.2 Develop Linkage System based on data.
	6.3 Review differences in Case Management practices.
	6.4 Incorporate differences in developing Linkage System.
	6.5 Create new data collection forms or instruments.
	OBJECTIVE 7.0: Provide feedback information about Linkage System.
	7.1 Package Case Management Linkage System.
	7.2 Present package to Advisory Committee.
	7.3 Record and collate feedback from Advisory Committee.
	7.4 Select relevant feedback data.

GOAL 3	CONTINUOUS PLANNING, IMPLEMENTATION, EVALUATION OF EDUCATION, MENTAL HEALTH AND RESIDENTIAL SERVICES.	
	OBJECTIVE 8.0:	**Modify Linkage System as needed.**
	8.1	Use data from 5.4 to modify Linkage System.
	8.2	Incorporate data into Linkage System.
	8.3	Finalize Linkage System.
	8.4	Create a Linkage System monitoring system.
	OBJECTIVE 9.0:	**To implement Linkage System.**
	9.1	Finalize computer software system design.
	9.2	Select agencies for trial run of Linkage System.
	9.3	Implement Linkage System among agencies.
	9.4	Monitor and collect data.
	9.5	Modify System based on trial run.
	9.6	Plan for full scale implementation of Case Management System.

GOAL 4	DIFFUSION OF EXEMPLARY POLICIES AND PROCEDURES.
	OBJECTIVE 1.0: Collect appropriate information and evaluate long and short range goals of the Project.
1.1	Review and refine goals, activities, evaluations, and timetables.
1.2	Determine questions to be addressed.
1.3	Assess strategies to insure documentation of all activities.
1.4	Determine evaluation components.
1.5	Develop surveys, needs assessments, and questionnaires.
1.6	Review and adjust flow charts and timetables.
1.7	Present evaluation components to Advisory Committee and BEES.
	OBJECTIVE 2.0: Document and develop strategies necessary for Project Management.
2.1	Develop agenda and minute keeping procedures.
2.2	Identify agency personnel to use as liaison.
2.3	Determine internal and external communication procedures.
2.4	Develop flow chart and timelines of tasks.
2.5	Provide update of Project's progress.
2.6	Submit budget reports to school personnel.
	OBJECTIVE 3.0: To develop and disseminate product reports.
3.1	Review and prioritize development of product reports.
3.2	Determine and submit format for technical reports.
3.3	Review product and dissemination activities.
3.4	Interchange long range product development with State Consultant.
3.5	Meet with State to determine dissemination activities.

SUMMARY OF
SED NETWORK ADVISORY COMMITTEE EVALUATION

MARY A. ELLZEY, PH.D.

JANUARY, 1984

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SUMMARY OF SED NETWORK ADVISORY COMMITTEE EVALUATION

PURPOSE: An instrument and procedure were designed to provide SED Network Advisory Committee members with an opportunity to provide objective, candid feedback on the structure and function of the Advisory Committee and other aspects of the Pinellas/Pasco SED Network. Information obtained was to be used to improve and maintain the Advisory Committee.

INSTRUMENT/PROCEDURE: An instrument consisting of 30 Likert type items, utilizing a scale of 1 = Strongly Agree to 5 = Strongly Disagree were developed by the Consultant and reviewed by members of the Consortium. Space was also provided for the respondents to provide comments for each item. In addition, an open-ended item seeking suggestions for improving the SED Network Advisory Committee was also provided.

The instrument was presented to the SED Network Advisory Committee on December 13, 1983. The purpose of the instrument and directions for completing and returning the instrument to the Consultant were discussed. A copy of the instrument was forwarded to Advisory Committee members who were not in attendance at the meeting. Telephone follow-up was conducted after the deadline for return of the instruments in an attempt to improve the response rate.

RESULTS: Sixty-six percent (66%) or 21 of the 32 SED Network Advisory Committee members responded to the instrument. Means were calculated for each of the items on the instrument and comments were compiled by item. Please see attached results and comments by item. Respondents rated all but four of the items, within the range of Strongly Agree to Agree ($\bar{x}$'s range from 1.2 to 1.9). The four items which were not rated within this range are as follows:

Item 14 - The role and responsibilities of committee members should be better defined ($\bar{x}$ = 2.9). The comments on this item indicated that there does not seem to be severe problems in the area of the role and responsibilities of advisory committee members. However, 8 respondents "agreed" that the roles and responsibilities should be better defined.

Item 15 - The role and responsibilities of the chairperson should be better defined ($\bar{x}$ = 3.4). A majority of the respondents were neutral or disagreed with this statement. The comments also reflect that there is no real concern in this area.

Item 19 - Participation in the SED Network increases my ability to impact on the legislative process ($\bar{x}$ = 2.3). The respondents generally "agreed" with the statement.

Item 21 - SED Network staff should spend more time serving as consultants to the Advisory Committee ($\bar{x}$ = 3.5). Respondents generally were neutral or disagreed with this statement. Comments supported this rating.

DISCUSSION: The ratings on the Likert type items and the comments indicate that the SED Network Advisory Committee is perceived as functioning very well by the members of the Committee. Efforts to organize and refine the membership and functioning of the Advisory Committee during the first year of the Pinellas/Pasco SED Network are bearing fruit. Representation of appropriate agencies on the Advisory Committee has been accomplished. Efforts to make sure that this status continues must be ongoing as new resources are developed within the community and as resource availability changes for existing agencies. Agencies which may need to be considered for membership are reflected in the comments of the respondents and include the Tampa Children's Home, Carlton Manor, a substance abuse provider, additional juvenile justice agencies, and Operation PAR.

The roles and responsibilities of SED Network Advisory Committee members, the Chairperson and the Co-chairperson have been defined and operationalized. The 1984 grant proposal provides a written description of the roles and responsibilities.

The operation of the Advisory Committee such as determining the location of meetings, the frequency and length of meetings, conduct of meetings, agenda development, and the content of meetings is perceived positively. Minutes of Advisory Committee meetings are being used effectively to document the proceedings of meetings.

Advisory Committee members perceive the relationships between the SED Network staff and the Advisory Committee as appropriate and effective. Verbal and written presentations by the Network staff are informative, accurate, complete, and timely. A question was designed to obtain Advisory Committee members reactions to the idea of staff spending more time as consultants to the Advisory Committee members. This proposed consultation role could impact on the functioning of the Advisory Committee, as well as upon other staff functions. The respondents did not agree that this was a needed change in staff responsibilities. Some additional discussion of the item (item 21) with the Advisory Committee may be helpful in fully understanding their position on the statement.

The impact of the SED Network Advisory Committee was addressed by several items. Respondents "strongly agreed" or "agreed" that:

- The SED Network Advisory Committee facilitates the improvement of services for SED students, within the agency I represent.
- The Advisory Committee facilitates my agency's ability to impact on other agencies serving SED students.
- Advisory Committee activities facilitate the accomplishment of SED Network activities.
- My agency benefits from its membership on the Advisory Committee.
- Participation in the SED Network increases my ability to impact on the legislative process.

DISCUSSION: Respondents express a general satisfaction with the structure and functioning of the SED Network Advisory Committee. It appears that the Advisory Committee should continue with its present structure and operational procedures. Periodically, members of the Advisory Committee should continue to provide evaluative feedback. Such evaluative feedback can be obtained informally, as well as through formal procedures. At some future date, it may also be appropriate to assess the impact of the Advisory Committee utilizing other evaluative strategies.

SED NETWORK ADVISORY COMMITTEE EVALUATION

n=21

	Mean
1. All appropriate agencies are represented on the Advisory Committee.	1.7

- Extreme care has been taken to include all appropriate representation.
- People who provide evaluations of SED children e.g., psychiatrists and psychologists and school psychologists.
- Perhaps the Children's Home (Tampa), more juvenile justice agencies as appropriate in '84.
- Carlton Manor is perhaps missing.
- Juvenile justice - representative should be appointed who will attend meetings and be actively involved.
- May add Operation PAR or hospitals.
- Need for more local school involvement i.e. teacher or social worker.
- Parents, Pinellas county schools.
- Add one substance abuse provider.

2. Advisory Committee meetings are held in a location which is convenient for me.	1.9

- Only five miles from my office.
- More scheduled for Pasco County.
- Most meetings are in Pinellas (central) and unavoidably difficult in distance from Pasco.
- It's nice that we move to have each travel only some of the time.
- Tampa, Pasco.
- Rotation of location is excellent idea.
- Pinellas County is much better (However, I acknowledge because of the committee make-up meetings must be held in Pasco).

3. The length of time scheduled for Advisory Committee meetings is adequate.	1.5

- We accomplish a lot in the given timeframe.
- Generally, the agenda is executed on schedule.

4. Procedures used for conducting Advisory Committee meetings provide for efficient progress of meetings.	1.4

- Very much so!
- All items are addressed adequately and expeditiously.

	Mean
5. I have adequate opportunity to place topics on the meeting agenda.	1.3
- no comments	
6. The regularly scheduled Advisory Committee meeting date (the third Tuesday) is convenient for me.	1.9
- I will have to be absent for a majority of 1984's meetings due to a standing time conflict. - Conflicts with another scheduled meeting. - Perfect!	
7. Ample time is provided for discussion of agenda items.	1.4
- The agenda is full but in most cases issues that are fully discussed are continued into the next meeting.	
8. The Advisory Committee meeting agenda is received in sufficient time for me to do any preparation which I might choose to do prior to the meeting.	1.6
- All meetings are prompt.	
9. I receive minutes of all Advisory Committee meetings.	1.2
- Very complete.	
10. Advisory Committee meeting minutes accurately reflect the proceedings of the meetings.	1.3
- Minutes are well documented.	
11. Minutes are disseminated within an appropriate amount of time after the meeting.	1.6
- With agenda for next meeting - appropriate. - I get them one week prior to meeting. - Very timely.	
12. The chairperson of the Advisory Committee should continue to be elected by the committee members.	1.2
- no comments.	

		Mean
13.	A co-chairperson with defined roles and responsibilities should continue to be elected by the committee.	1.3

- I believe there should be co-chairs with one being from Pasco and one the mental health program.
- Not sure if co-chair is actually necessary.
- Roles need to be defined.
- Somewhat.

14.	The role and responsibilities of committee members should be better defined.	2.9

- I understand my role.
- These have evolved to reflect appropriate involvement.
- Discuss during the first meeting of each year for review (old members) and orientation (new members).
- A review would be sufficient.

15.	The role and responsibilities of the chairperson should be better defined.	3.4

- Not yet completely understand what those responsibilities are.
- As defined in '84 grant is good.
- Care should be taker that chair does not experience a conflict of interest.
- Should remain an active participant in SED activities.

16.	The frequency of Advisory Committee meetings is adequate.	1.5

- no comments.

17.	Written information provided by SED Network staff is designed to inform Advisory Committee memebers on the Network's progress toward goal attainment.	1.4

- This has been provided in a timely and complete fashion.
- Well written.

18.	Agenda items primarily reflect issues which are critical to improving services for SED students.	1.6

- Not necessarily to "improving" services.
- The end result of all issues all basically to improve service.
- Issues reflect the growing cooperation of the network.

	Mean
19. Participation in the SED Network increases my ability to impact on the legislative process.	2.3
- Through the network staff. - The network will have impact but it doesn't impact my own ability.	
20. SED Network staff presentations to the advisory committee are accurate, complete, and timely.	1.4
- The staff is very competent.	
21. SED Network staff should spend more time serving as consultants to the Advisory Committee.	3.5
- Sufficient time is offered. - They appear to be doing a good job. - Time spent in this area is now adequate.	
22. I understand the job responsibilities of each of the SED Network staff members.	1.8
- Jobs were designed and developed in the first year - the coming year will make this issue clearer. - General responsibilities; I may not be aware of every activity due to not being involved on a daily basis.	
23. SED Network staff members are fulfilling their job responsibilities.	1.5
- It appears so, but this question may be premature to some extent. - Very well! (2) - To the best of my knowledge as indicated by production.	
24. Discussions held during Advisory Committee meetings provide for understanding and action on critical issues.	1.5
- no comments.	
25. The SED Network Advisory Committee facilitates the improvement of services for SED students, <u>within</u> the agency I represent.	1.6
- I still feel the orientation is primarily to services in Pinellas. - Information gained personally is aiding in the service I provide. - NA - As a funding agency, service elements do occur within.	

	Mean
26. The Advisory Committee facilitates my agency's ability to impact on other agencies serving SED students.	1.6
- Has been very helpful to our needs assessment and planning activities.	
27. Advisory Committee activities indicate that the SED Network is accomplishing its goals and objectives.	1.6
- It's easy to track from agenda items to the grant - progress on goals.	
28. Advisory Committee activities facilitate the accomplishment of SED Network goals and objectives.	1.8
- no comments.	
29. My agency benefits from its membership on the Advisory Committee.	1.6
- The communication among agencies is very helpful. - Input, joint planning, information.	
30. I am satisfied with the structure and functioning of the Advisory Committee.	1.6
- Extremely organized. - Having been involved in its development, I am satisfied.	

The SED Network Advisory Committee Could Be Improved By:

- Adding some professionals from the school systems evaluation process, i.e. school psychologists and school social workers who provide first line intervention and evaluation/or provide for systematic flow of information to them.
- Less updates on project activities i.e., periodic updates rather than updates each meeting.
- Meeting in a variety of locations such as Pasco or Tampa.

Other Comments:

- Dr. Sherry is doing a great job!
- The subject approaches a goal for which I have worked with the Pinellas schools system for nearly seven years. It needs only to be expanded in scope and strength.
- The network should begin plans to develop into a "consultant group" to the school and mental health systems which provides technical assistance statewide after the grant terminates in 4 years.
- 1983 was a good year for the Network.